Visual Software

MDS 3.0

User Manual

PRELIMINARY

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Reliable Health Systems, LLC
2610 Nostrand Avenue
Brooklyn, NY 11210

www.ReliableHealth.com

Tel: 718-338-2400
Fax: 718-338-2741

VISUAL MDS 3.0
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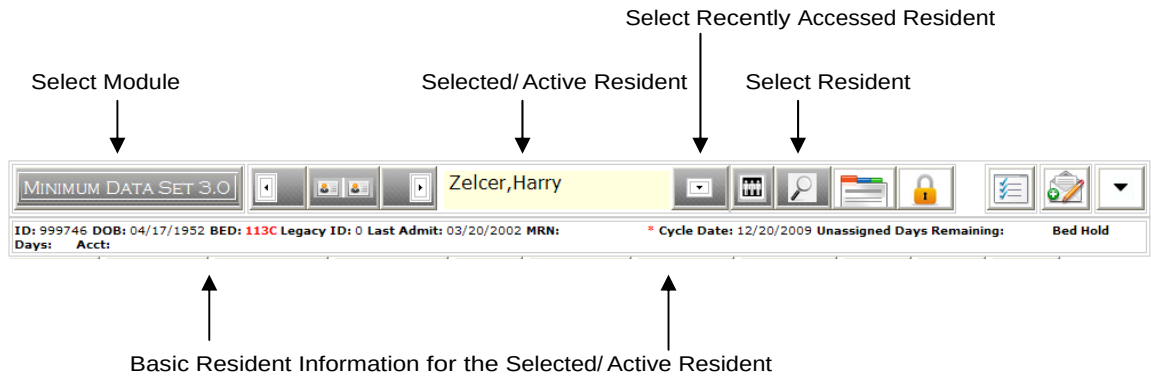
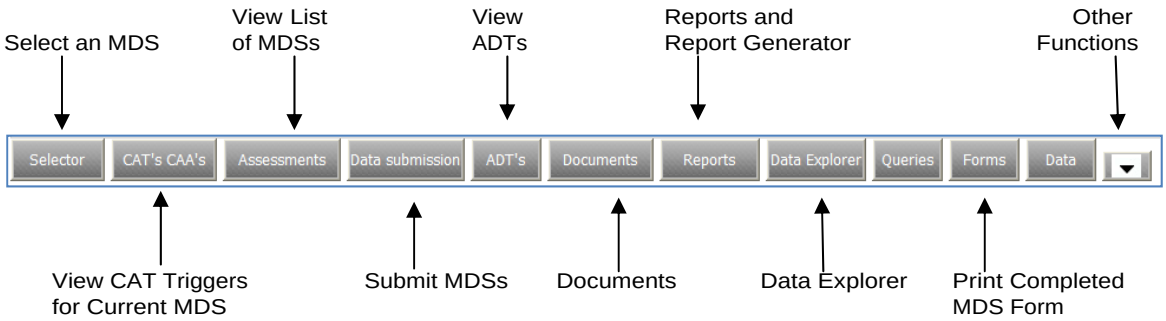
Main MDS 3.0 Tool-bar Functions:


Select Recently Accessed Resident
Select Module
Selected/ Active Resident
Select Resident
MINIMUM DATA SET 3.0
Zelcer,Harry
ID: 999746 DOB: 04/17/1952 BED: 113C Legacy ID: 0 Last Admit: 03/20/2002 MRN:
* Cycle Date: 12/20/2009 Unassigned Days Remaining:
Bed Hold
Days:
Acct:
Basic Resident Information for the Selected/ Active Resident

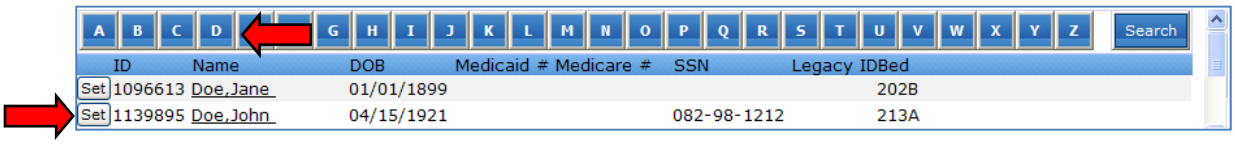


Resizing the MDS Screen

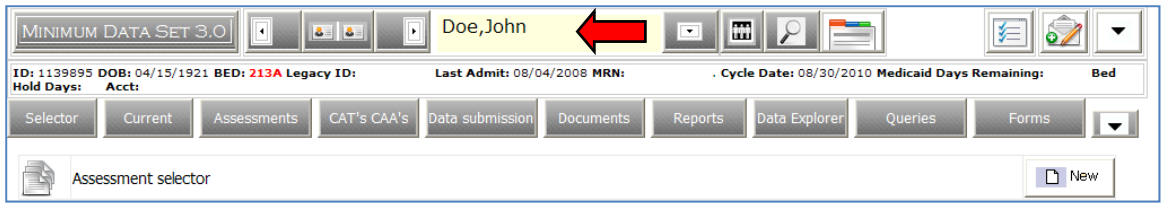
Selecting a Resident

To select a resident click on the Magnifying Glass icon as shown below: (Alternately you can clear the existing resident name and type the last few letters of the resident's last name.)

Click on the first letter of the last name of the resident. For example, if you want to select "John Doe" click on the letter "**D**" as shown below and then click on "**Set**" alongside the proper name.

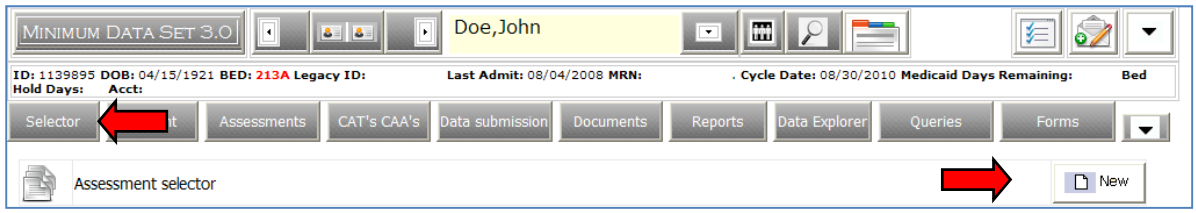

A B C D G H I J K L M N O P Q R S T U V W X Y Z
Search
ID Name DOB Medicaid # Medicare # SSN Legacy ID Bed
Set 1096613 Doe,Jane 01/01/1899 202B
Set 1139895 Doe,John 04/15/1921 082-98-1212 213A

Notice on the screen below that "John Doe" is now the active resident.

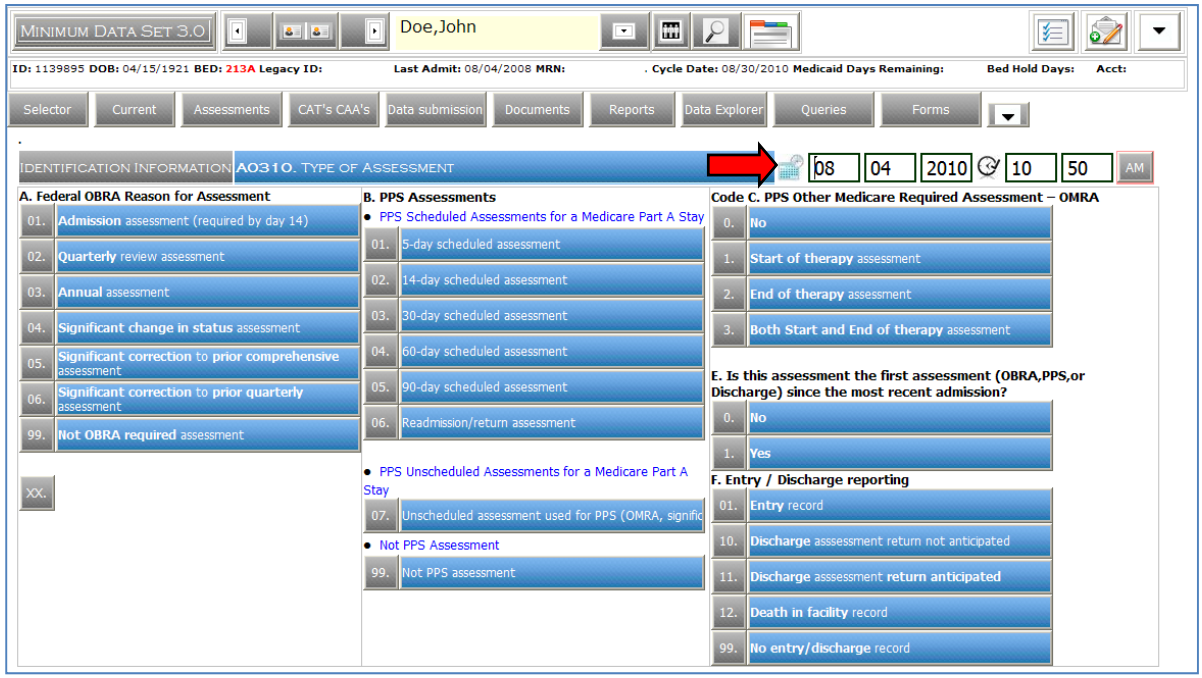


Creating a New MDS Record

To create a new MDS record click on "Selector" and then click on "New" as shown below:



The following screen appears:

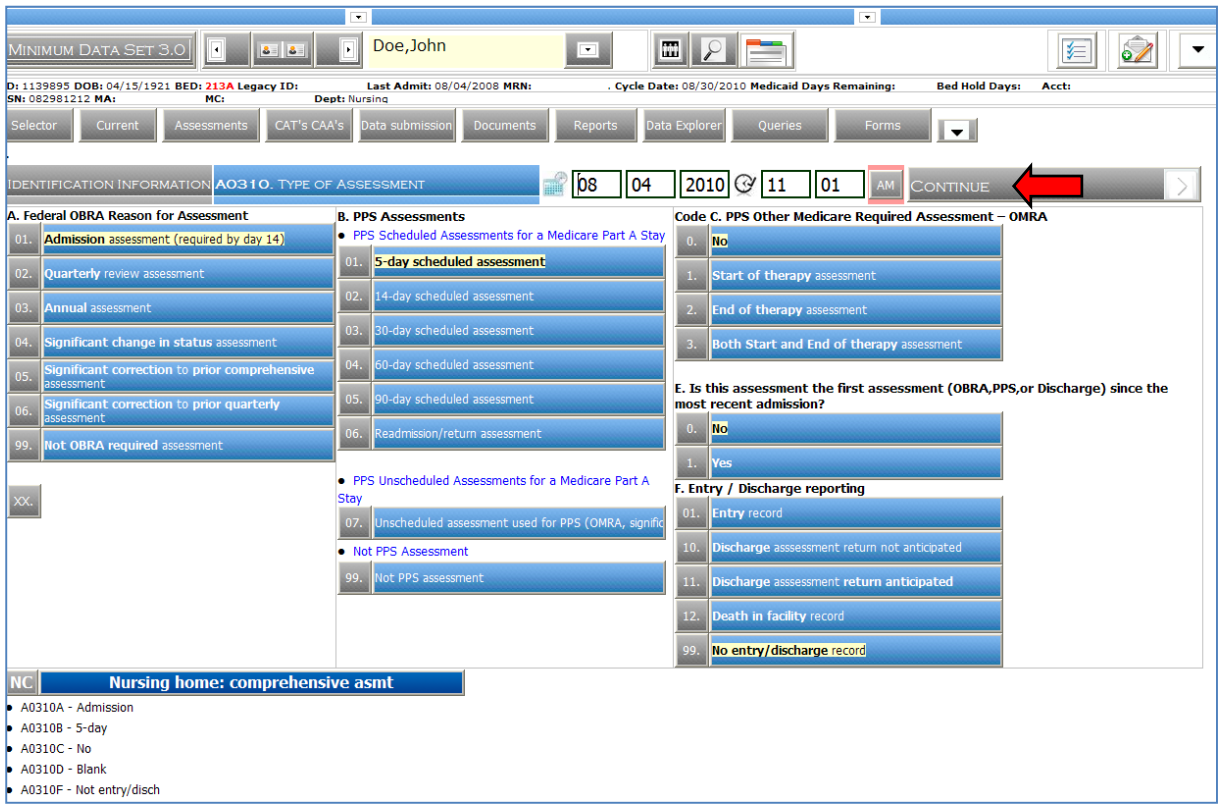

MINIMUM DATA SET 3.0
Doe,John
ID: 1139895 DOB: 04/15/1921 BED: 213A Legacy ID:
Last Admit: 08/04/2008 MRN:
. Cycle Date: 08/30/2010 Medicaid Days Remaining:
Bed Hold Days:
Acct:
Selector
Current
Assessments
CAT's CAA's
Data submission
Documents
Reports
Data Explorer
Queries
Forms
IDENTIFICATION INFORMATION
A0310. TYPE OF ASSESSMENT
08 04 2010 10 50 AM
A. Federal OBRA Reason for Assessment
01. Admission assessment (required by day 14)
02. Quarterly review assessment
03. Annual assessment
04. Significant change in status assessment
05. Significant correction to prior comprehensive assessment
06. Significant correction to prior quarterly assessment
99. Not OBRA required assessment
XX.
B. PPS Assessments
• PPS Scheduled Assessments for a Medicare Part A Stay
01. 5-day scheduled assessment
02. 14-day scheduled assessment
03. 30-day scheduled assessment
04. 60-day scheduled assessment
05. 90-day scheduled assessment
06. Readmission/return assessment
• PPS Unscheduled Assessments for a Medicare Part A Stay
07. Unscheduled assessment used for PPS (OMRA, signific
• Not PPS Assessment
99. Not PPS assessment
Code C. PPS Other Medicare Required Assessment – OMRA
0. No
1. Start of therapy assessment
2. End of therapy assessment
3. Both Start and End of therapy assessment
E. Is this assessment the first assessment (OBRA,PPS,or Discharge) since the most recent admission?
0. No
1. Yes
F. Entry / Discharge reporting
01. Entry record
10. Discharge asssessment return not anticipated
11. Discharge asssessment return anticipated
12. Death in facility record
99. No entry/discharge record

You can now date the new MDS record. The system assumes the current date and time but you can change this. See the screen above.

Notice above that there are five (5) ways to classify the MDS:

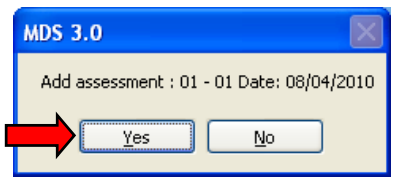
A. Federal OBRA Reason for Assessment
B. PPS Assessment
C. PPS Other Medicare Required Assessment – OMRA
E. Is this Assessment the first assessment since admission?
F. Entry/Discharge reporting

It is necessary to select one MDS type from within **each** of the 5 groups. For example a new admission could be selected as shown below:



A. Federal OBRA Reason for Assessment - "**01**"
B. PPS Assessment "**01**"
C. PPS Other Medicare Required Assessment – OMRA - "**0**"
E. Is this Assessment the first assessment since admission? - "**0**"
F. Entry/Discharge reporting - "**99**"

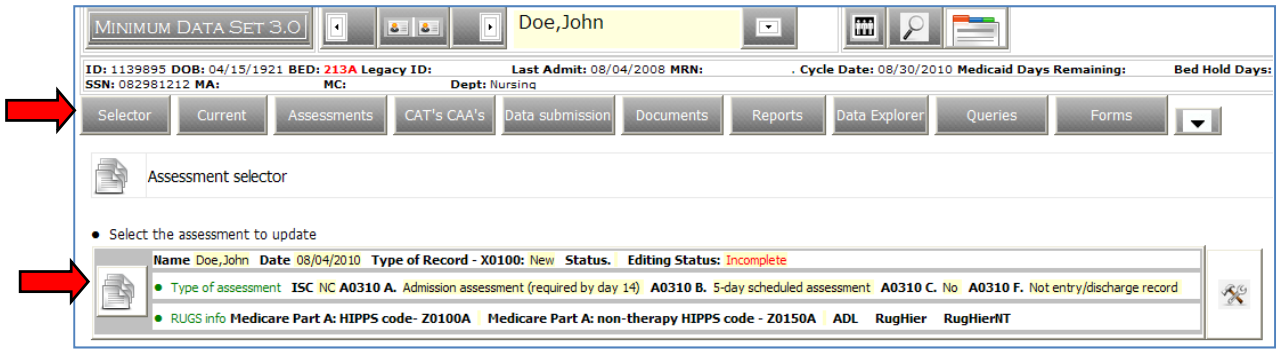
Notice that the "Continue" button now appears on the screen above. Click on the "Continue" button and you will be asked whether you wish to create the MDS record. Click "Yes" as shown below.



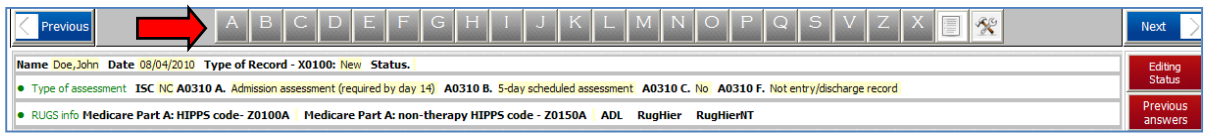
The new MDS record is created:

Selecting an MDS Record

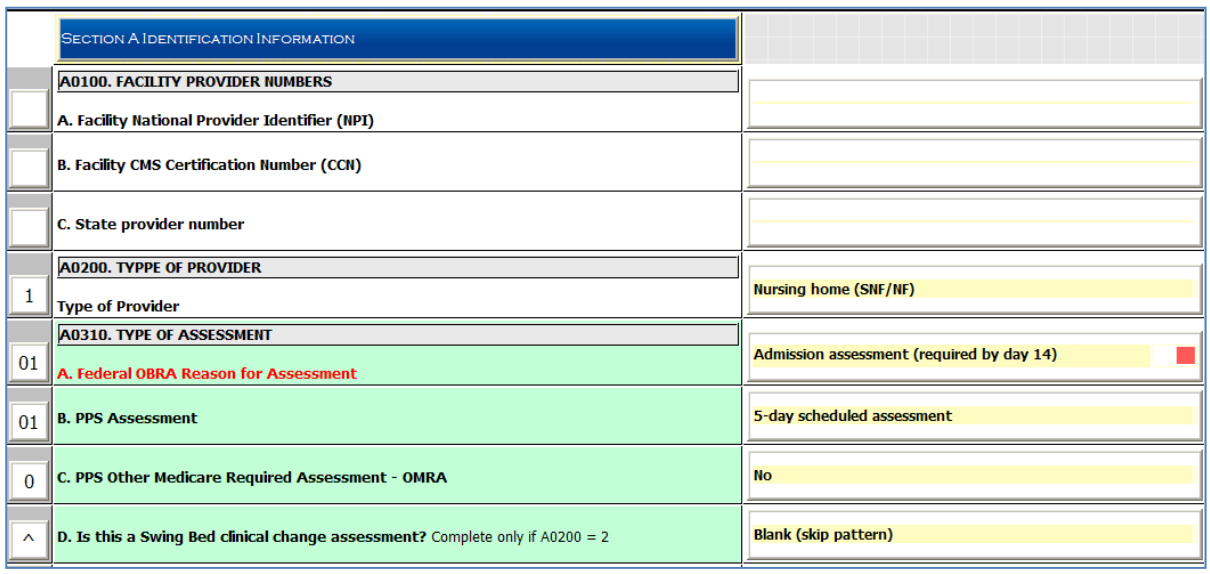
To select an MDS record for resident John Doe click on "Selector" and then click on the "Open" icon alongside the MDS. In the example below there is only one MDS record.


MINIMUM DATA SET 3.0
Doe,John
ID: 1139895 DOB: 04/15/1921 BED: 213A Legacy ID: Last Admit: 08/04/2008 MRN: . Cycle Date: 08/30/2010 Medicaid Days Remaining: Bed Hold Days:
SSN: 082981212 MA: MC: Dept: Nursing
Selector
Current
Assessments
CAT's CAA's
Data submission
Documents
Reports
Data Explorer
Queries
Forms
Assessment selector
Select the assessment to update
Name Doe,John Date 08/04/2010 Type of Record - X0100: New Status. Editing Status: Incomplete
Type of assessment ISC NC A0310 A. Admission assessment (required by day 14) A0310 B. 5-day scheduled assessment A0310 C. No A0310 F. Not entry/discharge record
RUGS info Medicare Part A: HIPPS code- Z0100A Medicare Part A: non-therapy HIPPS code - Z0150A ADL RugHier RugHierNT

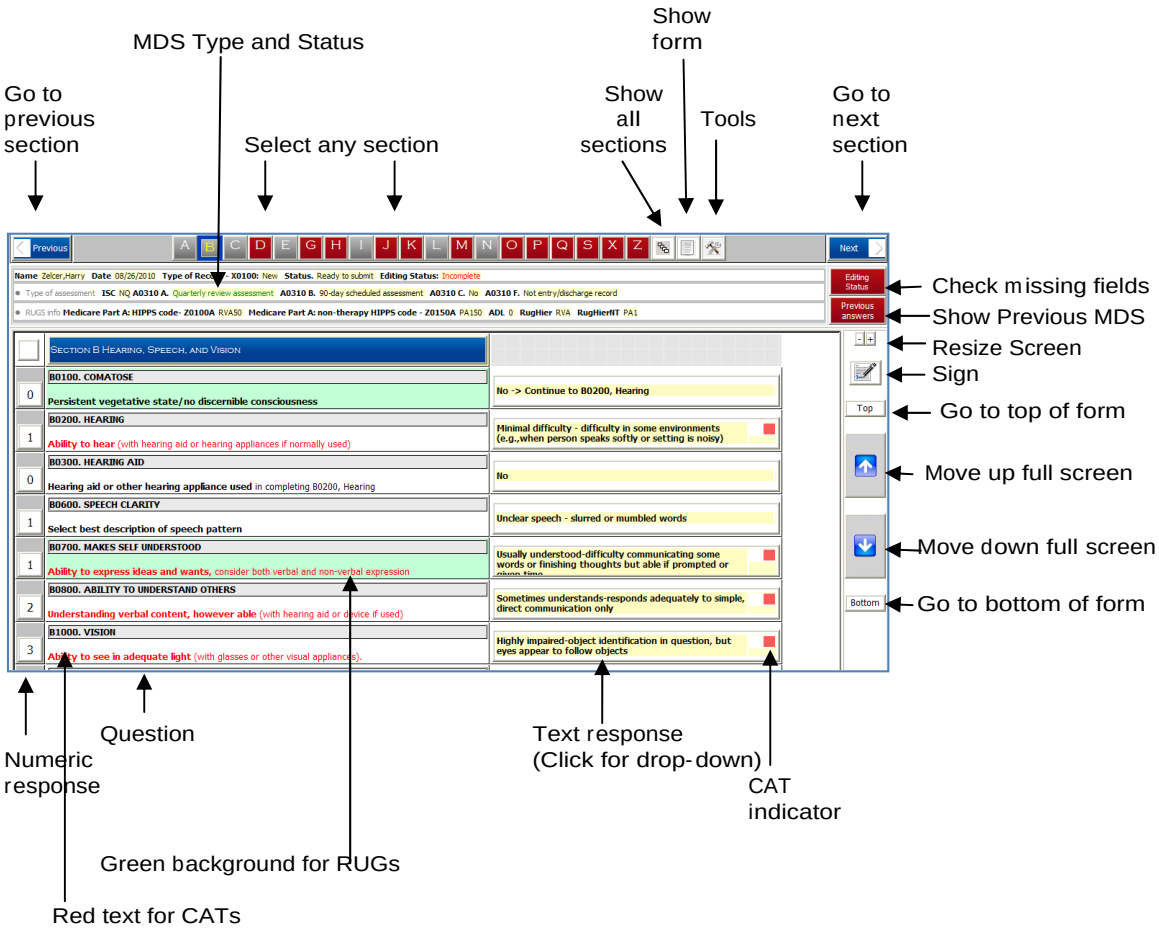
The following appears. You can now click on any section to begin entering MDS information. For example to enter information for section A, click on "A" as shown below:


Previous
A B C D E F G H I J K L M N O P Q S V Z X
Next
Name Doe,John Date 08/04/2010 Type of Record - X0100: New Status.
Editing Status
Type of assessment ISC NC A0310 A. Admission assessment (required by day 14) A0310 B. 5-day scheduled assessment A0310 C. No A0310 F. Not entry/discharge record
RUGS info Medicare Part A: HIPPS code- Z0100A Medicare Part A: non-therapy HIPPS code - Z0150A ADL RugHier RugHierNT
Previous answers

Section "A" appears as shown below:

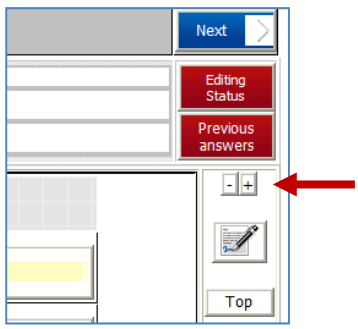

SECTION A IDENTIFICATION INFORMATION
A0100. FACILITY PROVIDER NUMBERS
A. Facility National Provider Identifier (NPI)
B. Facility CMS Certification Number (CCN)
C. State provider number
A0200. TYPPE OF PROVIDER
1
Type of Provider
Nursing home (SNF/NF)
A0310. TYPE OF ASSESSMENT
01
A. Federal OBRA Reason for Assessment
Admission assessment (required by day 14)
01
B. PPS Assessment
5-day scheduled assessment
0
C. PPS Other Medicare Required Assessment - OMRA
No
D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
Blank (skip pattern)

Quick Guide



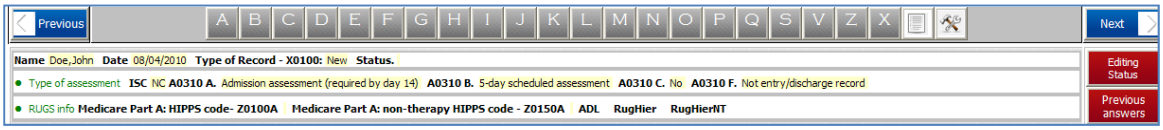
Resizing the MDS 3.0 Screen

To maximize the area on your screen for MDS 3.0 we advise you to use "kiosk" mode by pressing function key "F11". Depending on the physical size of your monitor you will then need to fine-tune your screen. As shown below click on "+" to increase the screen area available for MDS 3.0, or click on "-" to decrease it.



Moving from One Section to Another

Use the functionality of the buttons on the toolbar as shown below to move from one section to another in the MDS as follows:


Previous
A B C D E F G H I J K L M N O P Q S V Z X
Next
Name Doe,John Date 08/04/2010 Type of Record - X0100: New Status.
Type of assessment ISC NC A0310 A. Admission assessment (required by day 14) A0310 B. 5-day scheduled assessment A0310 C. No A0310 F. Not entry/discharge record
RUGS info Medicare Part A: HIPPS code- Z0100A Medicare Part A: non-therapy HIPPS code - Z0150A ADL RugHier RugHierNT
Editing Status
Previous answers

Click "Next" to move from your current section to the next.

Click "Previous" to move from your current section to the previous.

You may also click on any section to move directly to that section.

Moving Within a Section

Click on the blue vertical bar and drag it to scroll up and down within the MDS.

Click on "Top" to move to the top of the section

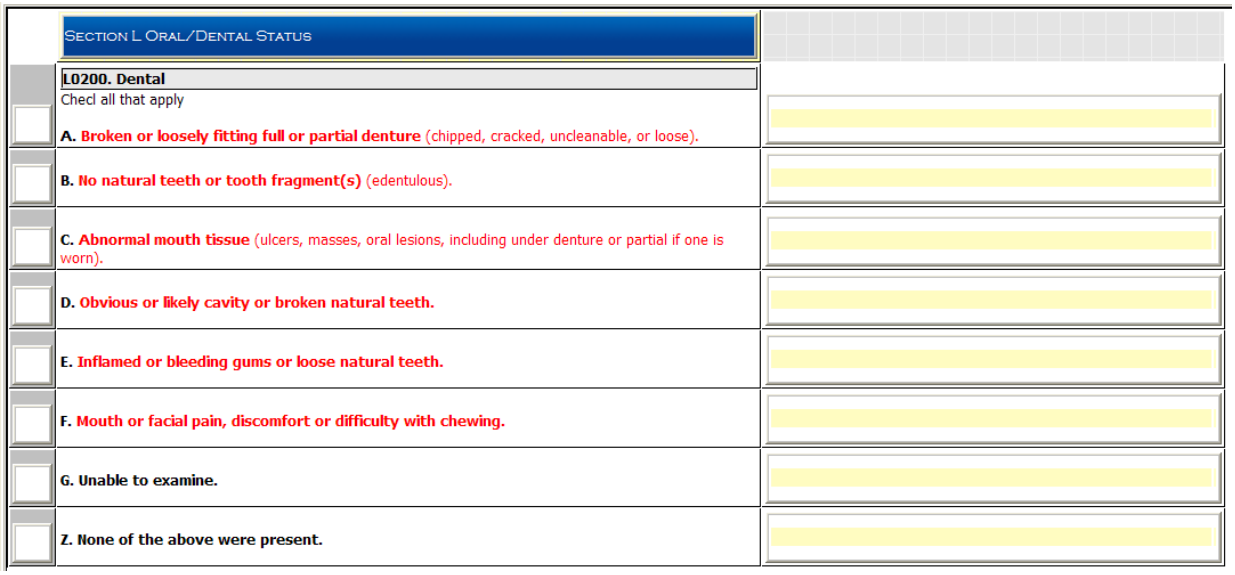
Click on the "Up Arrow" to move up an entire screen-full.

Click on the "Down Arrow" to move down an entire screen-full.

Click on "Bottom" to move to the bottom of the screen.

Entering Information into an MDS

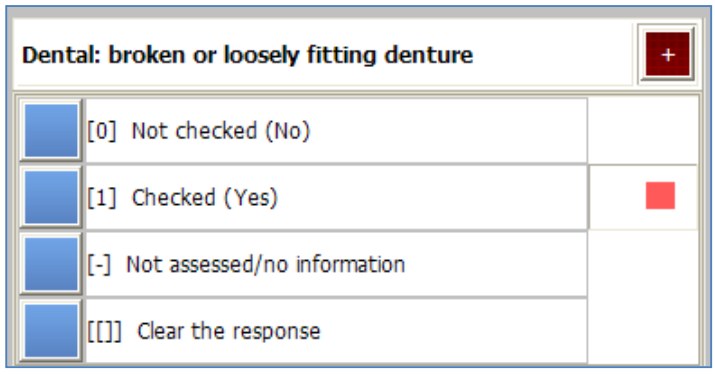
Section "L" is shown below. Note that the words of certain questions appear in red. This indicates that this question may affect one or more CATs. (See the following section for more details on the use of red and green colors.)



	SECTION L ORAL/DENTAL STATUS	
	L0200. Dental Checl all that apply **A. Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose).	
	B. No natural teeth or tooth fragment(s) (edentulous).	
	C. Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn).	
	D. Obvious or likely cavity or broken natural teeth.	
	E. Inflamed or bleeding gums or loose natural teeth.	
	F. Mouth or facial pain, discomfort or difficulty with chewing.	
	G. Unable to examine.	
	Z. None of the above were present.	

Click on the right hand side (yellow box) alongside any question to enter a value for that field.

For example, to enter a value for "Broken or loosely fitting full of partial dentures" click on the yellow alongside the question and the following choices appear:



Click on the appropriate answer to select your choice. The red box indicates that if you select "[1] Checked (Yes)" it will affect a CAT.

Note: If you move the cursor out of the box the set of choices disappear.

Understanding the Usage of Red and Green Colors

Red and Green are used to indicate respectively the potential for RUGs and CATs.

Questions are color coded as follow:

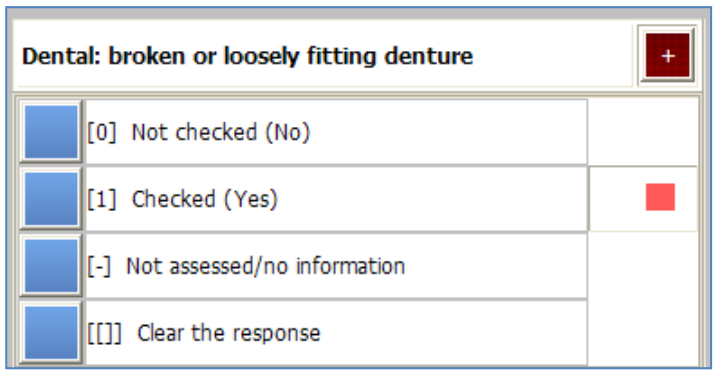
When the words appear red there is a potential for a CAT trigger.

When the background appears in green in will affect RUG reimbursement.

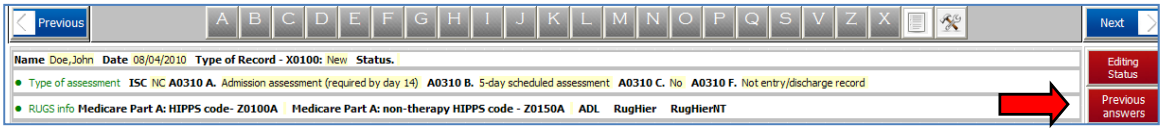
When it affects both RUGs and CATs is appear in red on green

Answers are color coded as follows:

When a red box appears alongside an answer it indicates that it affects a CAT trigger. See the illustration below:



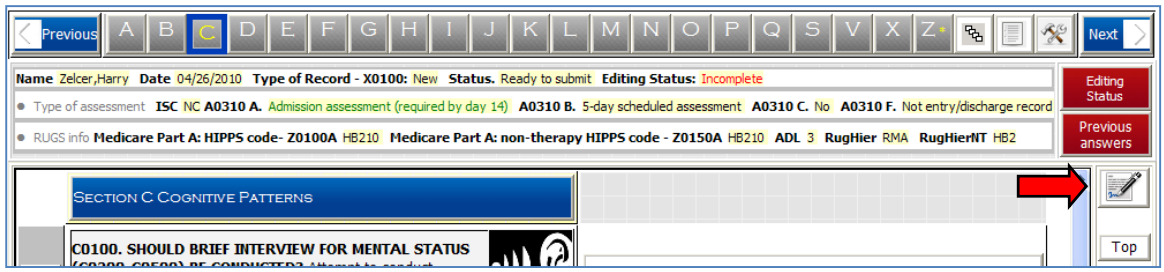
Show Answers from the Previous MDS


Previous
A B C D E F G H I J K L M N O P Q S V Z X
Next
Name Doe,John Date 08/04/2010 Type of Record - X0100: New Status.
Type of assessment ISC NC A0310 A. Admission assessment (required by day 14) A0310 B. 5-day scheduled assessment A0310 C. No A0310 F. Not entry/discharge record
RUGS info Medicare Part A: HIPPS code- Z0100A Medicare Part A: non-therapy HIPPS code - Z0150A ADL RugHier RugHierNT
Editing Status
Previous answers

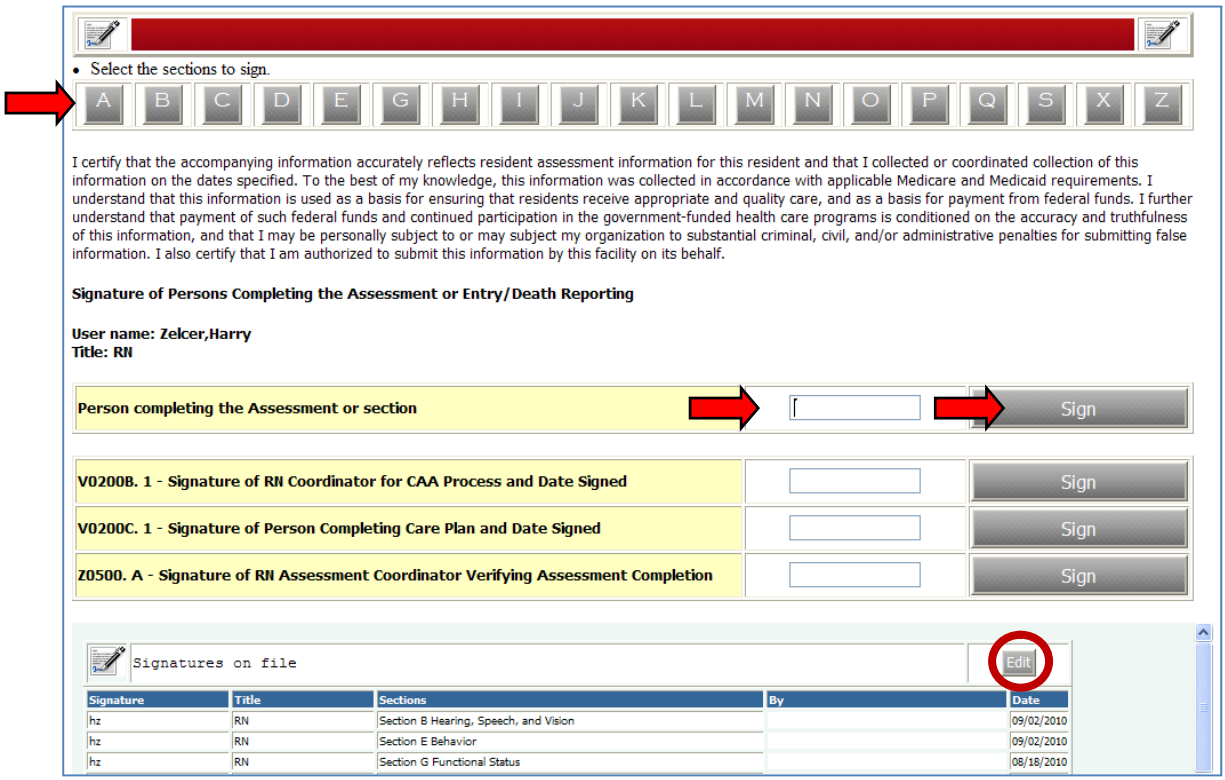
Click on "Previous Answers" to show the values entered on the previous MDS. Click the button once to show the previous answers, click it a second time to not show the previous answers.

Signing the MDS

To sign the MDS click on the signature icon as shown below:


Previous
A B C D E F G H I J K L M N O P Q S V X Z*
Next
Name Zelcer,Harry Date 04/26/2010 Type of Record - X0100: New Status. Ready to submit Editing Status: Incomplete
Type of assessment ISC NC A0310 A. Admission assessment (required by day 14) A0310 B. 5-day scheduled assessment A0310 C. No A0310 F. Not entry/discharge record
RUGS info Medicare Part A: HIPPS code- Z0100A HB210 Medicare Part A: non-therapy HIPPS code - Z0150A HB210 ADL 3 RugHier RMA RugHierNT HB2
Editing Status
Previous answers
SECTION C COGNITIVE PATTERNS
C0100. SHOULD BRIEF INTERVIEW FOR MENTAL STATUS
Top

The following screen appears:


Select the sections to sign.
A B C D E G H I J K L M N O P Q S X Z
I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.
Signature of Persons Completing the Assessment or Entry/Death Reporting
User name: Zelcer,Harry
Title: RN
Person completing the Assessment or section
Sign
V0200B. 1 - Signature of RN Coordinator for CAA Process and Date Signed
Sign
V0200C. 1 - Signature of Person Completing Care Plan and Date Signed
Sign
Z0500. A - Signature of RN Assessment Coordinator Verifying Assessment Completion
Sign
Signatures on file
Edit
Signature Title Sections By Date
hz RN Section B Hearing, Speech, and Vision 09/02/2010
hz RN Section E Behavior 09/02/2010
hz RN Section G Functional Status 08/18/2010

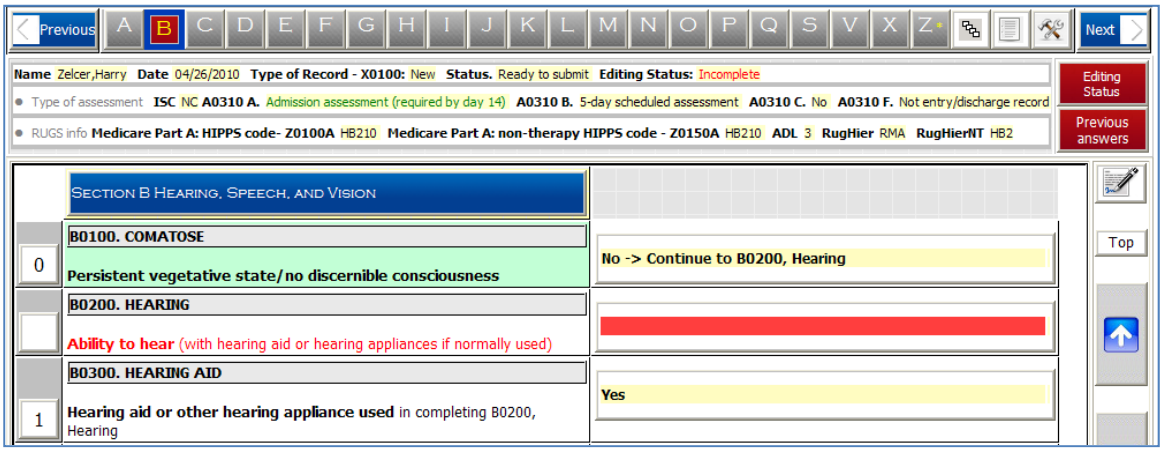
1. As shown above click on each section you wish to sign. A "✓" appears.
2. Type your password as indicated above.
3. Click on "Sign".

Notice that you can also sign questions "V0200B", "V0200C" and "Z0500".

If a section was signed in error click on "Edit" as circled above. You can then change the section signed or delete the signature. See page 19 for more details.

Error Checking: On the Section Bar

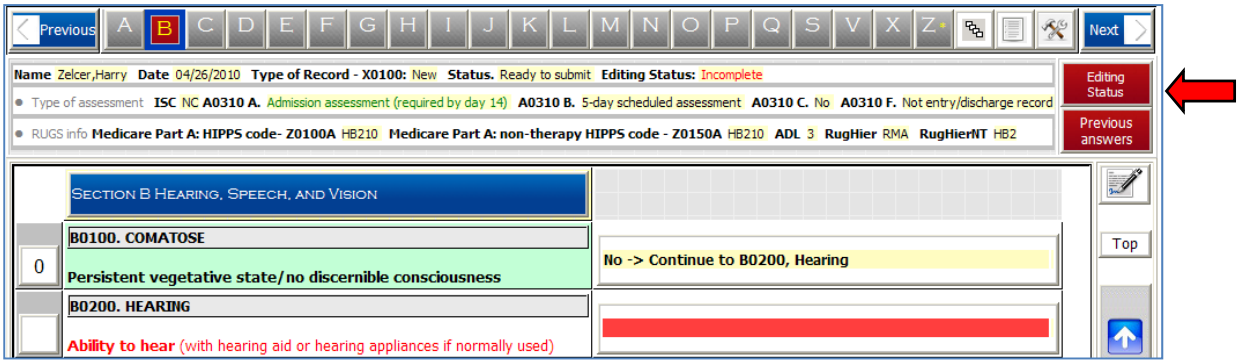
Error checking is done dynamically, on both the section level and the field level, as you enter the information into the MDS. For example, in the screen below question "B0200" is not completed:


Previous
A B C D E F G H I J K L M N O P Q S V X Z*
Next
Name Zelcer,Harry Date 04/26/2010 Type of Record - X0100: New Status. Ready to submit Editing Status: Incomplete
Type of assessment ISC NC A0310 A. Admission assessment (required by day 14) A0310 B. 5-day scheduled assessment A0310 C. No A0310 F. Not entry/discharge record
RUGS info Medicare Part A: HIPPS code- Z0100A HB210 Medicare Part A: non-therapy HIPPS code - Z0150A HB210 ADL 3 RugHier RMA RugHierNT HB2
Editing Status
Previous answers
SECTION B HEARING, SPEECH, AND VISION
B0100. COMATOSE
0
Persistent vegetative state/no discernible consciousness
No -> Continue to B0200, Hearing
B0200. HEARING
Ability to hear (with hearing aid or hearing appliances if normally used)
B0300. HEARING AID
Yes
1
Hearing aid or other hearing appliance used in completing B0200, Hearing
Top

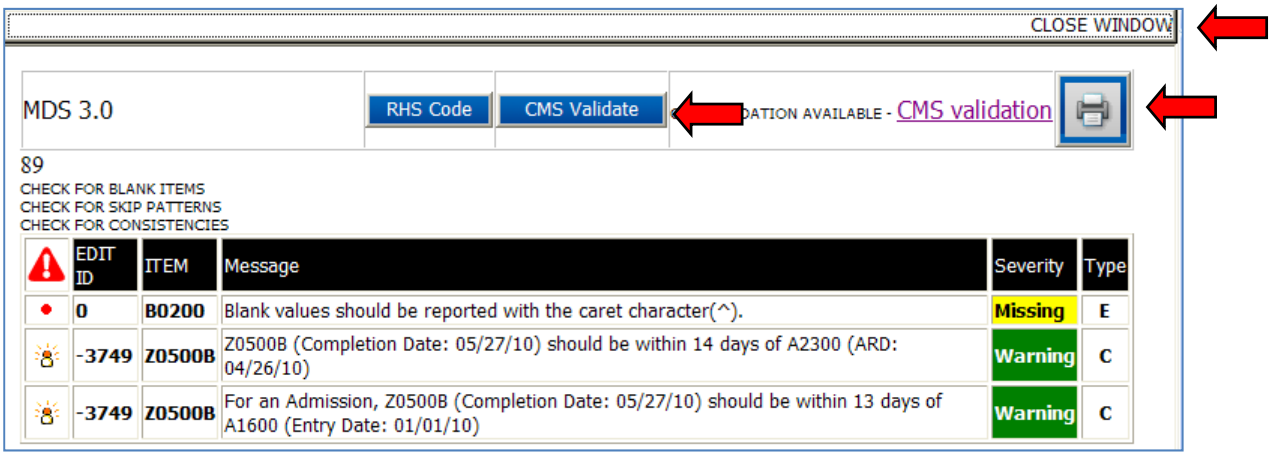
Notice the following indicators above:

1. A red bar appears alongside "B0200" indicating the field is missing.
2. The section "B" square button appears in red indicting the section is not complete.
3. Unrelated to "B0200" being incomplete, notice that an "*" appears in the section "Z" box. This indicates that although section "Z" is complete there is a warning. A Warning may appear, for example, when the date entered indicates that the assessment is late.

Error Checking: The "Editing Status" Icon


Previous
A B C D E F G H I J K L M N O P Q S V X Z
Next
Name Zelcer,Harry Date 04/26/2010 Type of Record - X0100: New Status. Ready to submit Editing Status: Incomplete
Type of assessment ISC NC A0310 A. Admission assessment (required by day 14) A0310 B. 5-day scheduled assessment A0310 C. No A0310 F. Not entry/discharge record
RUGS info Medicare Part A: HIPPS code- Z0100A HB210 Medicare Part A: non-therapy HIPPS code - Z0150A HB210 ADL 3 RugHier RMA RugHierNT HB2
Editing Status
Previous answers
SECTION B HEARING, SPEECH, AND VISION
B0100. COMATOSE
0
Persistent vegetative state/no discernible consciousness
No -> Continue to B0200, Hearing
B0200. HEARING
Ability to hear (with hearing aid or hearing appliances if normally used)
Top

To check the completion status of the entire MDS click on "Editing Status" as shown above. The following screen appears:



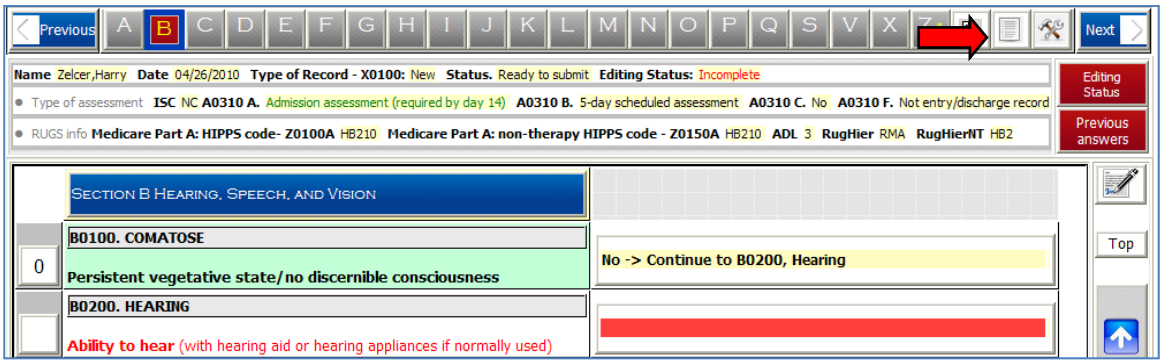
Notice that three errors are noted above. The first is in section "B" (question "B0200") and the next two are warnings for section "Z" (both of which apply to the date entered for question "Z0500B," Completion Date.)

You can print the list of errors by clicking on the "Print" icon as shown above.

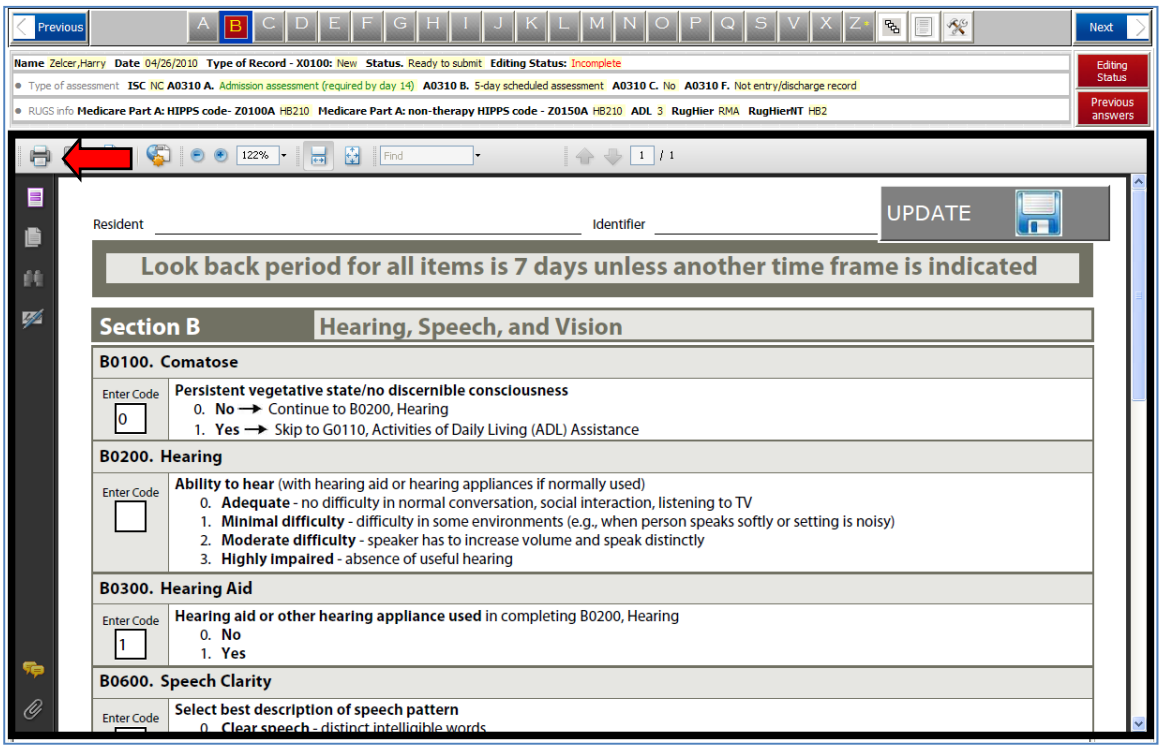
You can close the error listing by clicking on "CLOSE WINDOW". As shown above.

This error checking is quick and efficient. We recommend, however, that before you finalize the MDS you should also run the official CMS validation by clicking on "CMS Validate" as shown above. This CMS error checking, however, takes about 20 seconds.

Seeing and Printing the Official MDS Form for the Section on Which You are Working


Previous
A B C D E F G H I J K L M N O P Q S V X Z
Next
Name Zelcer,Harry Date 04/26/2010 Type of Record - X0100: New Status. Ready to submit Editing Status: Incomplete
Type of assessment ISC NC A0310 A. Admission assessment (required by day 14) A0310 B. 5-day scheduled assessment A0310 C. No A0310 F. Not entry/discharge record
RUGS info Medicare Part A: HIPPS code- Z0100A HB210 Medicare Part A: non-therapy HIPPS code - Z0150A HB210 ADL 3 RugHier RMA RugHierNT HB2
Editing Status
Previous answers
SECTION B HEARING, SPEECH, AND VISION
B0100. COMATOSE
0
Persistent vegetative state/no discernible consciousness
No -> Continue to B0200, Hearing
B0200. HEARING
Ability to hear (with hearing aid or hearing appliances if normally used)
Top

To view and print the official MDS form for the section on which you are working click on the icon as shown above. The form appears as follows:

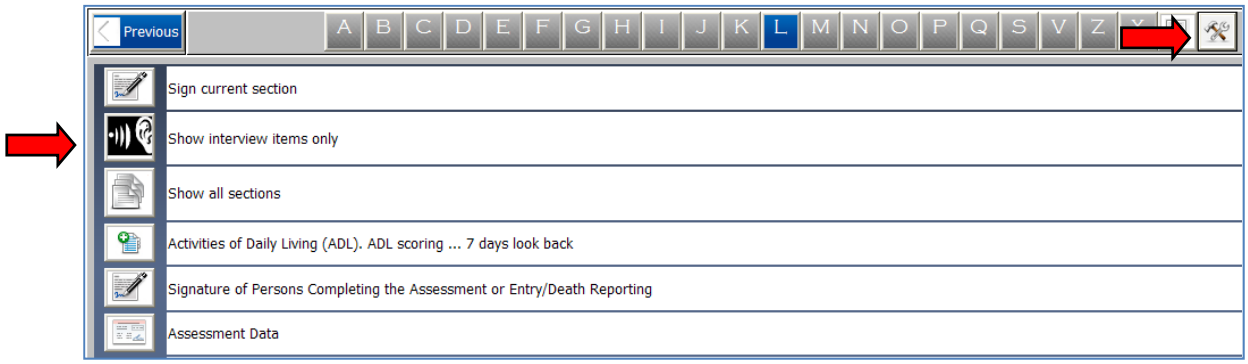

Previous
Next
Resident
Identifier
UPDATE
Look back period for all items is 7 days unless another time frame is indicated
Section B
Hearing, Speech, and Vision
B0100. Comatose
Enter Code
0
Persistent vegetative state/no discernible consciousness
0. No → Continue to B0200, Hearing
1. Yes → Skip to G0110, Activities of Daily Living (ADL) Assistance
B0200. Hearing
Enter Code
Ability to hear (with hearing aid or hearing appliances if normally used)
0. Adequate - no difficulty in normal conversation, social interaction, listening to TV
1. Minimal difficulty - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. Moderate difficulty - speaker has to increase volume and speak distinctly
3. Highly impaired - absence of useful hearing
B0300. Hearing Aid
Enter Code
1
Hearing aid or other hearing appliance used in completing B0200, Hearing
0. No
1. Yes
B0600. Speech Clarity
Enter Code
Select best description of speech pattern
0. Clear speech - distinct intelligible words

The section appears with the answers you entered. You can now print that section by clicking on the print icon as shown above.

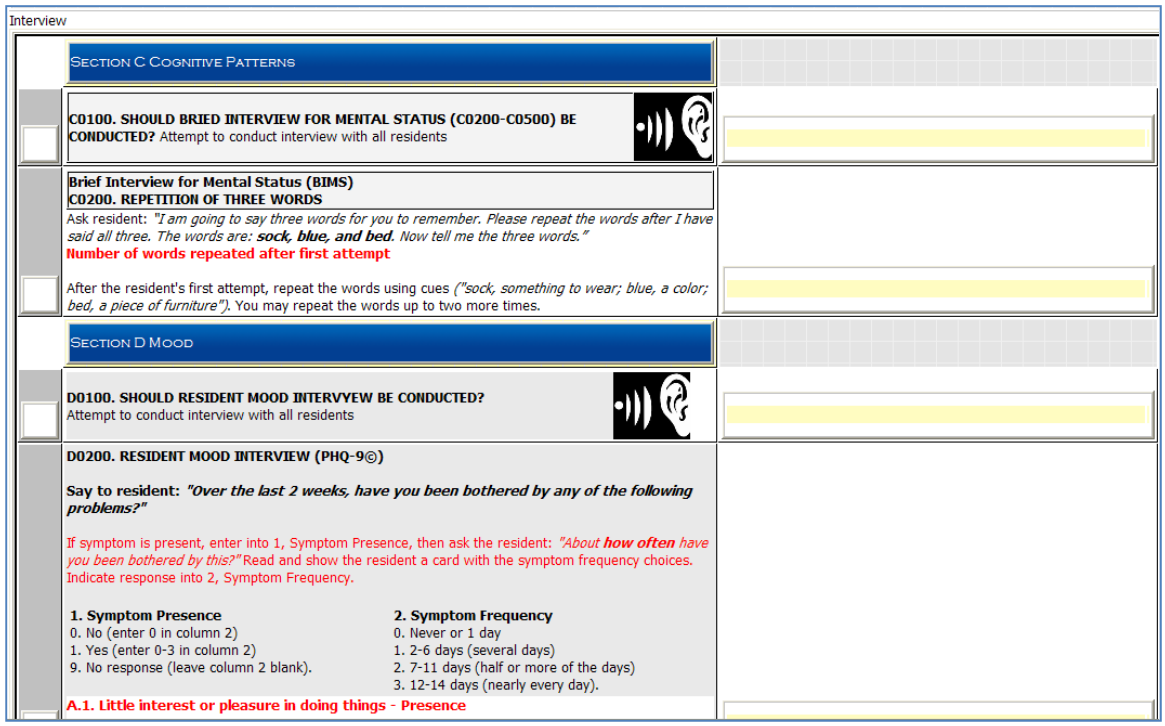
To continue completing the MDS click on any section icon.

Show and Edit All Interview Questions

When you are doing the resident interview it is helpful to see all the interview questions together. To see and edit all interview questions do the following:

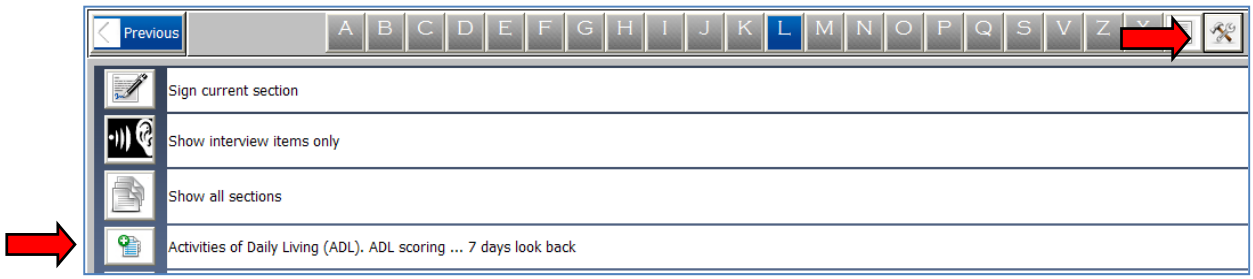

Previous
A B C D E F G H I J K L M N O P Q S V Z
Sign current section
Show interview items only
Show all sections
Activities of Daily Living (ADL). ADL scoring ... 7 days look back
Signature of Persons Completing the Assessment or Entry/Death Reporting
Assessment Data

Click on the tool icon and then on the "Show interview items only" icon. All interview items appear as shown below:

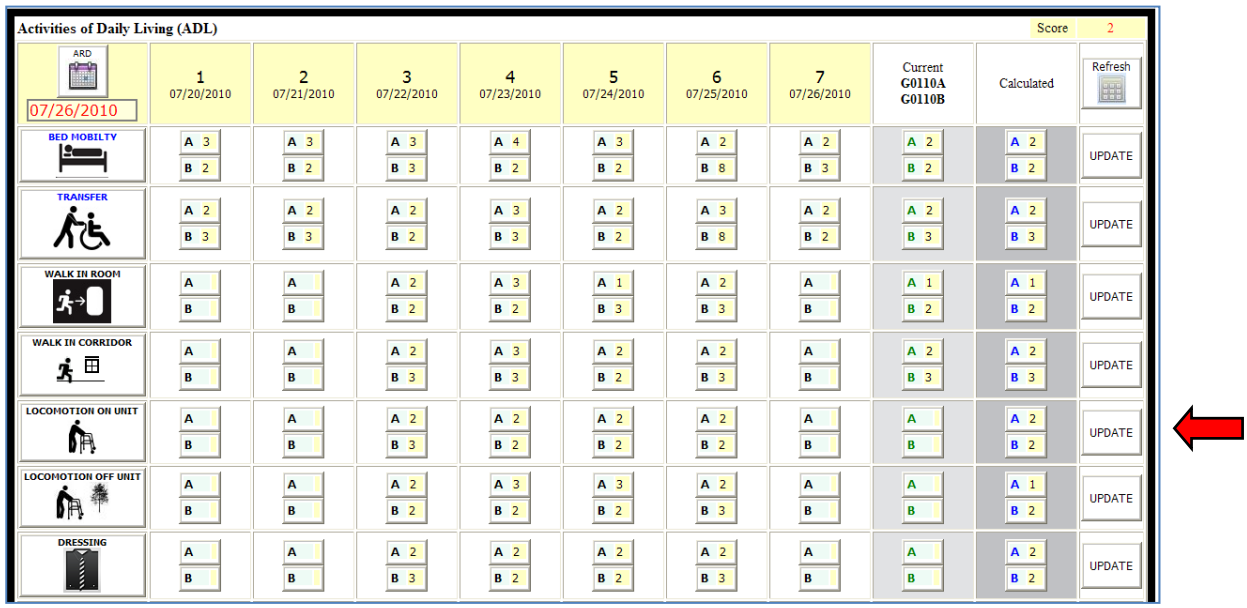

Interview
SECTION C COGNITIVE PATTERNS
C0100. SHOULD BRIED INTERVIEW FOR MENTAL STATUS (C0200-C0500) BE CONDUCTED? Attempt to conduct interview with all residents
Brief Interview for Mental Status (BIMS)
C0200. REPETITION OF THREE WORDS
Ask resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."
Number of words repeated after first attempt
After the resident's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.
SECTION D MOOD
D0100. SHOULD RESIDENT MOOD INTERVYEW BE CONDUCTED?
Attempt to conduct interview with all residents
D0200. RESIDENT MOOD INTERVIEW (PHQ-9©)
Say to resident: "Over the last 2 weeks, have you been bothered by any of the following problems?"
If symptom is present, enter into 1, Symptom Presence, then ask the resident: "About how often have you been bothered by this?" Read and show the resident a card with the symptom frequency choices. Indicate response into 2, Symptom Frequency.
1. Symptom Presence
0. No (enter 0 in column 2)
1. Yes (enter 0-3 in column 2)
9. No response (leave column 2 blank).
2. Symptom Frequency
0. Never or 1 day
1. 2-6 days (several days)
2. 7-11 days (half or more of the days)
3. 12-14 days (nearly every day).
A.1. Little interest or pleasure in doing things - Presence

Activities of Daily Living

To update your ADLs (Section G) based on the information entered by your CNAs do the following:


Previous
A B C D E F G H I J K L M N O P Q S V Z
Sign current section
Show interview items only
Show all sections
Activities of Daily Living (ADL). ADL scoring ... 7 days look back

Click on the tool icon and then on the "Activities of Daily Living" icon. The followings screen appears:

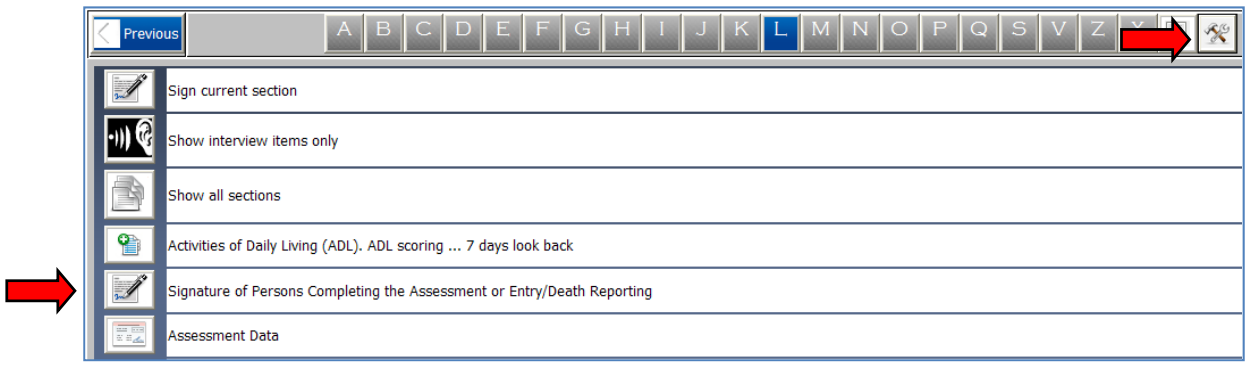


Alongside any ADL click on the "Update" button to move the CNA scores (i.e., the scores in the "Calculated" column) into the current MDS (replacing the MDS values shown in the "Current G0110A G0110B" column).

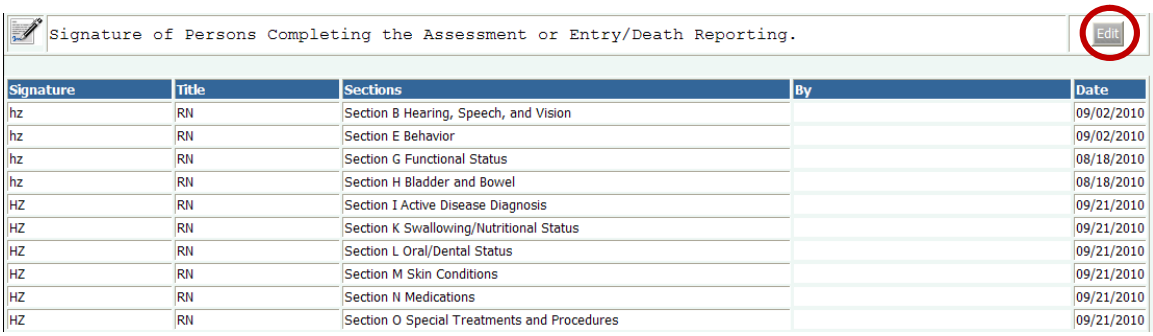
For example, to update the ADLs for "Locomotion On Unit" click on the "Update" button as shown above.

Signatures of Persons Completing the Assessment

To view a list of the people who signed the MDS do the following:


Previous
A B C D E F G H I J K L M N O P Q S V Z
Sign current section
Show interview items only
Show all sections
Activities of Daily Living (ADL). ADL scoring ... 7 days look back
Signature of Persons Completing the Assessment or Entry/Death Reporting
Assessment Data

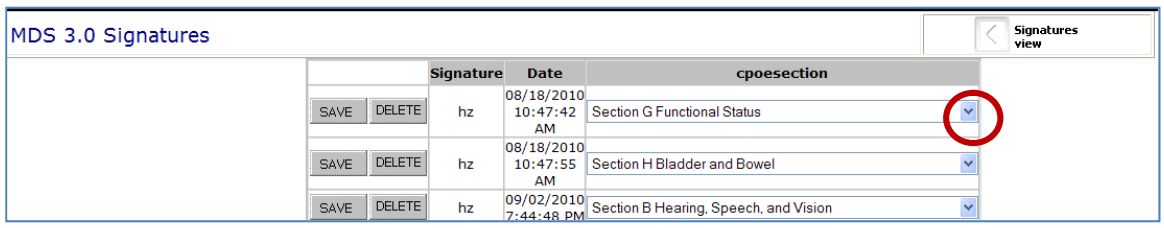
Click on the tool icon and then on the "Signatures of Persons completing the Assessment" icon. The following screen appears:



Signature	Title	Sections	By	Date
hz	RN	Section B Hearing, Speech, and Vision		09/02/2010
hz	RN	Section E Behavior		09/02/2010
hz	RN	Section G Functional Status		08/18/2010
hz	RN	Section H Bladder and Bowel		08/18/2010
HZ	RN	Section I Active Disease Diagnosis		09/21/2010
HZ	RN	Section K Swallowing/Nutritional Status		09/21/2010
HZ	RN	Section L Oral/Dental Status		09/21/2010
HZ	RN	Section M Skin Conditions		09/21/2010
HZ	RN	Section N Medications		09/21/2010
HZ	RN	Section O Special Treatments and Procedures		09/21/2010

The signatures of the people who signed the MDS appear along with the sections they signed and the date it was signed.

If a section was signed in error click on edit as shown above and the following screen appears:

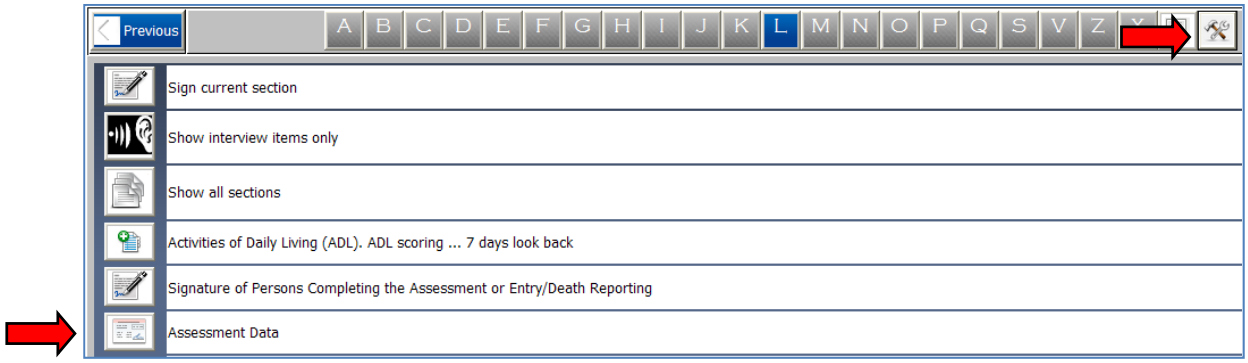

MDS 3.0 Signatures
Signatures view
Signature
Date
cpoesection
SAVE DELETE hz 08/18/2010 10:47:42 AM Section G Functional Status
SAVE DELETE hz 08/18/2010 10:47:55 AM Section H Bladder and Bowel
SAVE DELETE hz 09/02/2010 7:44:48 PM Section B Hearing, Speech, and Vision

To change the section: click on the blue dropdown, select the proper section and click "SAVE".

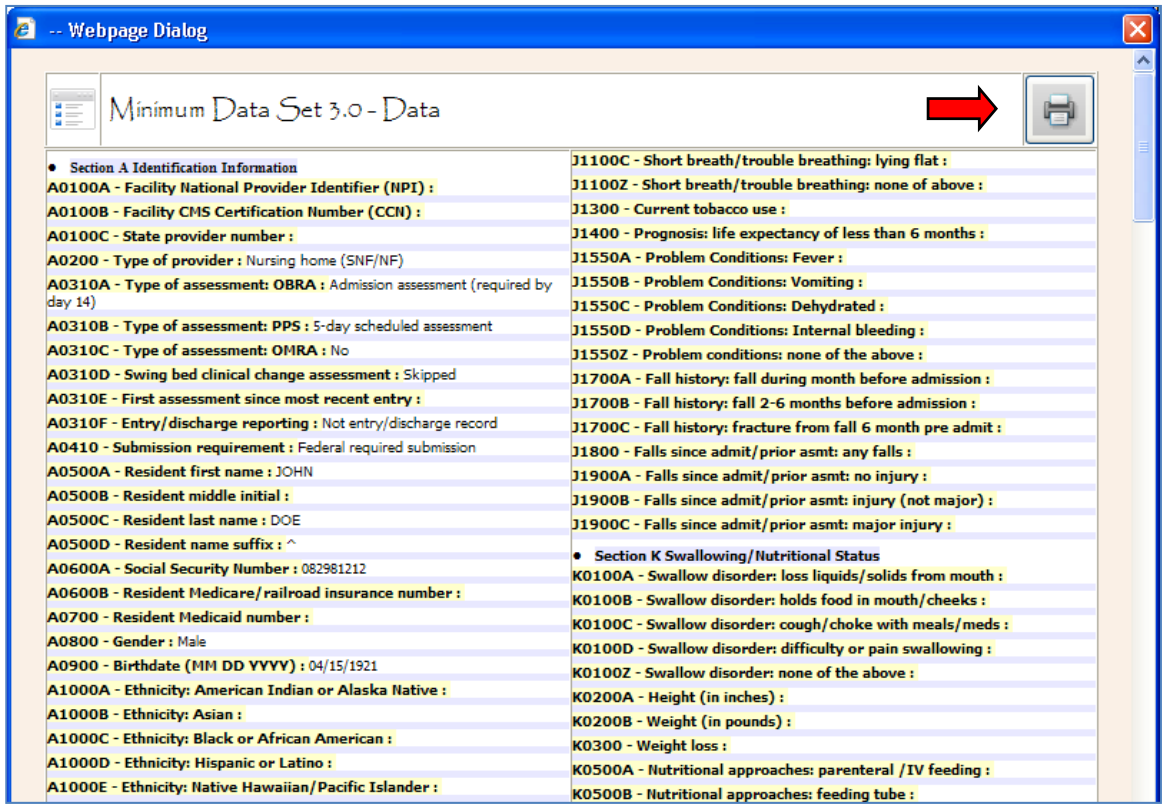
To delete a section, click on "DELETE".

Assessment Data – A Compact View

To print out the MDS in a Compact View (i.e., using fewer sheets) do the following:


Previous
A B C D E F G H I J K L M N O P Q S V Z
Sign current section
Show interview items only
Show all sections
Activities of Daily Living (ADL). ADL scoring ... 7 days look back
Signature of Persons Completing the Assessment or Entry/Death Reporting
Assessment Data

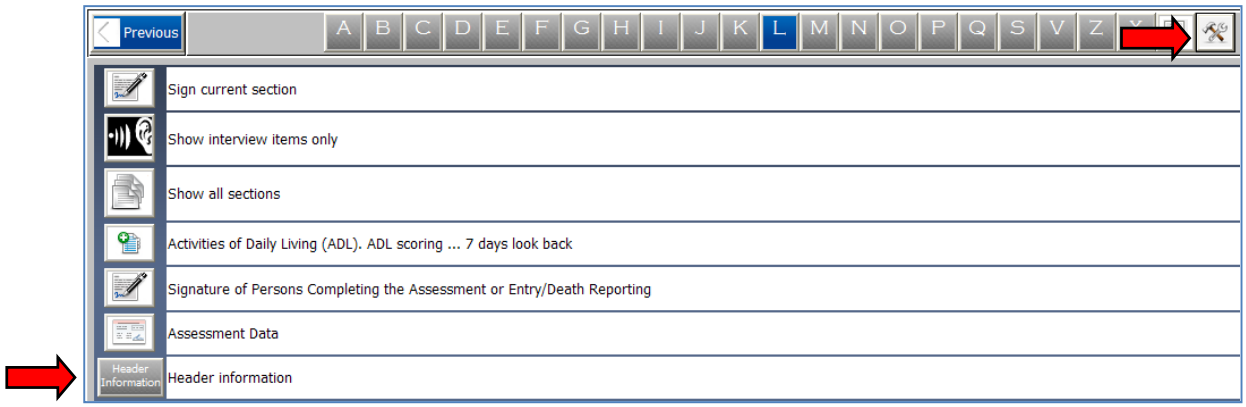
Click on the tool icon and then on the "Assessment Data" icon. The following screen appears:


-- Webpage Dialog
Minimum Data Set 3.0 - Data
• Section A Identification Information
A0100A - Facility National Provider Identifier (NPI) :
A0100B - Facility CMS Certification Number (CCN) :
A0100C - State provider number :
A0200 - Type of provider : Nursing home (SNF/NF)
A0310A - Type of assessment: OBRA : Admission assessment (required by day 14)
A0310B - Type of assessment: PPS : 5-day scheduled assessment
A0310C - Type of assessment: OMRA : No
A0310D - Swing bed clinical change assessment : Skipped
A0310E - First assessment since most recent entry :
A0310F - Entry/discharge reporting : Not entry/discharge record
A0410 - Submission requirement : Federal required submission
A0500A - Resident first name : JOHN
A0500B - Resident middle initial :
A0500C - Resident last name : DOE
A0500D - Resident name suffix : ^
A0600A - Social Security Number : 082981212
A0600B - Resident Medicare/railroad insurance number :
A0700 - Resident Medicaid number :
A0800 - Gender : Male
A0900 - Birthdate (MM DD YYYY) : 04/15/1921
A1000A - Ethnicity: American Indian or Alaska Native :
A1000B - Ethnicity: Asian :
A1000C - Ethnicity: Black or African American :
A1000D - Ethnicity: Hispanic or Latino :
A1000E - Ethnicity: Native Hawaiian/Pacific Islander :
J1100C - Short breath/trouble breathing: lying flat :
J1100Z - Short breath/trouble breathing: none of above :
J1300 - Current tobacco use :
J1400 - Prognosis: life expectancy of less than 6 months :
J1550A - Problem Conditions: Fever :
J1550B - Problem Conditions: Vomiting :
J1550C - Problem Conditions: Dehydrated :
J1550D - Problem Conditions: Internal bleeding :
J1550Z - Problem conditions: none of the above :
J1700A - Fall history: fall during month before admission :
J1700B - Fall history: fall 2-6 months before admission :
J1700C - Fall history: fracture from fall 6 month pre admit :
J1800 - Falls since admit/prior asmt: any falls :
J1900A - Falls since admit/prior asmt: no injury :
J1900B - Falls since admit/prior asmt: injury (not major) :
J1900C - Falls since admit/prior asmt: major injury :
• Section K Swallowing/Nutritional Status
K0100A - Swallow disorder: loss liquids/solids from mouth :
K0100B - Swallow disorder: holds food in mouth/cheeks :
K0100C - Swallow disorder: cough/choke with meals/meds :
K0100D - Swallow disorder: difficulty or pain swallowing :
K0100Z - Swallow disorder: none of the above :
K0200A - Height (in inches) :
K0200B - Weight (in pounds) :
K0300 - Weight loss :
K0500A - Nutritional approaches: parenteral /IV feeding :
K0500B - Nutritional approaches: feeding tube :

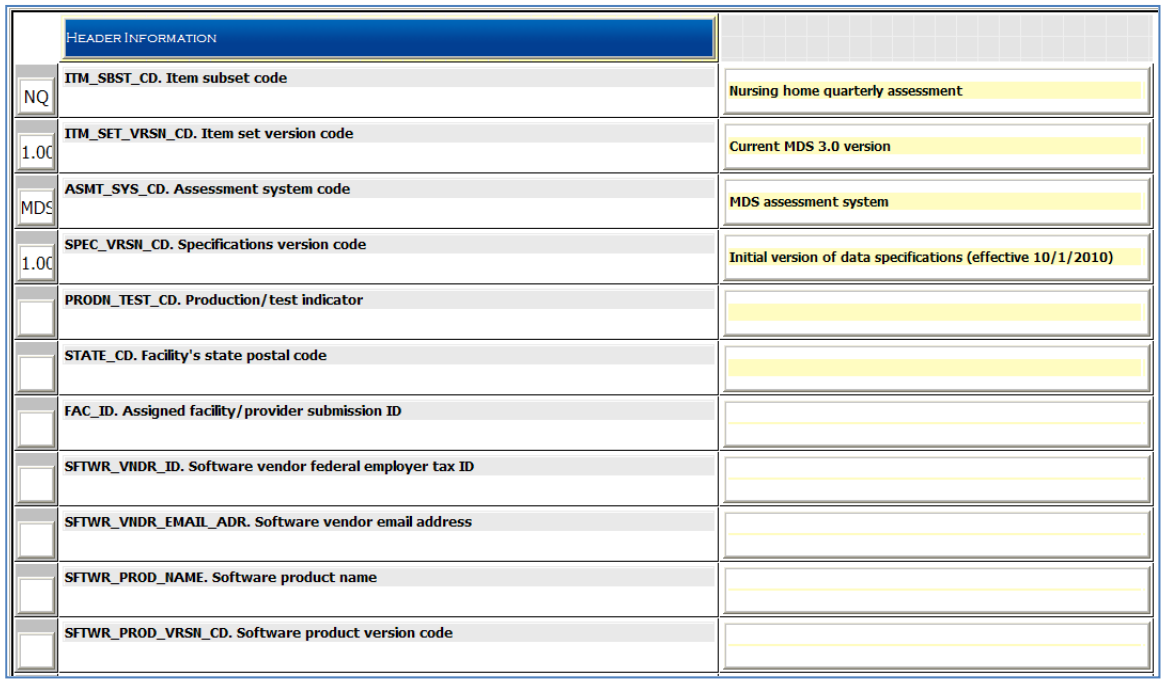
Click on the print icon as shown above to print the MDS in compact form.

Header Information

To view and edit the MDS header information do the following:


Previous
A B C D E F G H I J K L M N O P Q S V Z
Sign current section
Show interview items only
Show all sections
Activities of Daily Living (ADL). ADL scoring ... 7 days look back
Signature of Persons Completing the Assessment or Entry/Death Reporting
Assessment Data
Header Information
Header information

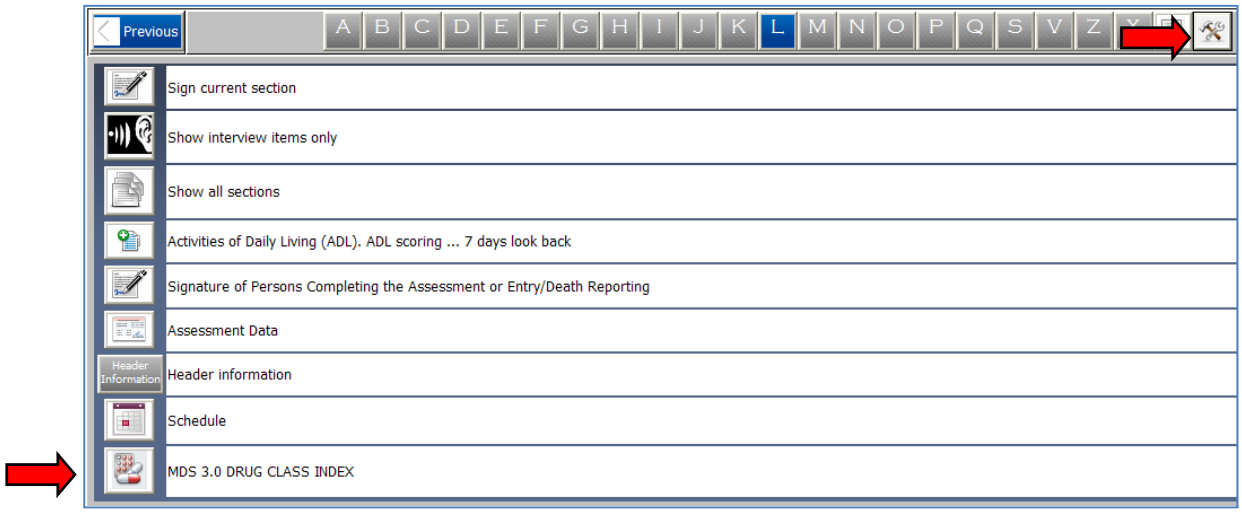
Click on the tool icon and then on the "Header Information" icon. The following screen appears:



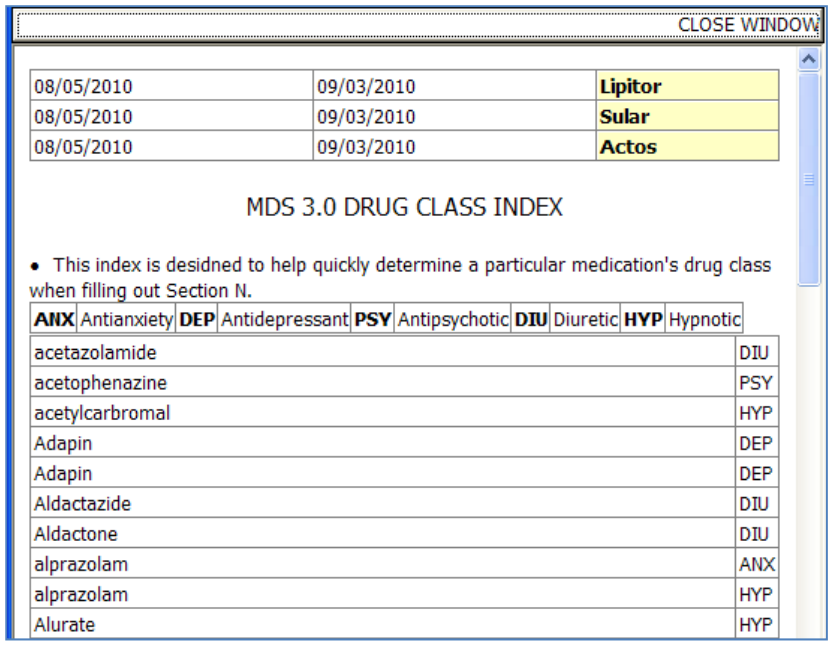
Note: There should be no need for you to edit the Header Information; all information in the Header Section is being filled in by the software. If you get an error on the Header Information section contact your RHS client service representative.

MDS 3.0 Drug Class Index

To view the resident's medications and the Medication classifications needed for section "N" do the following:


Previous
A B C D E F G H I J K L M N O P Q S V Z
Sign current section
Show interview items only
Show all sections
Activities of Daily Living (ADL). ADL scoring ... 7 days look back
Signature of Persons Completing the Assessment or Entry/Death Reporting
Assessment Data
Header Information
Header information
Schedule
MDS 3.0 DRUG CLASS INDEX

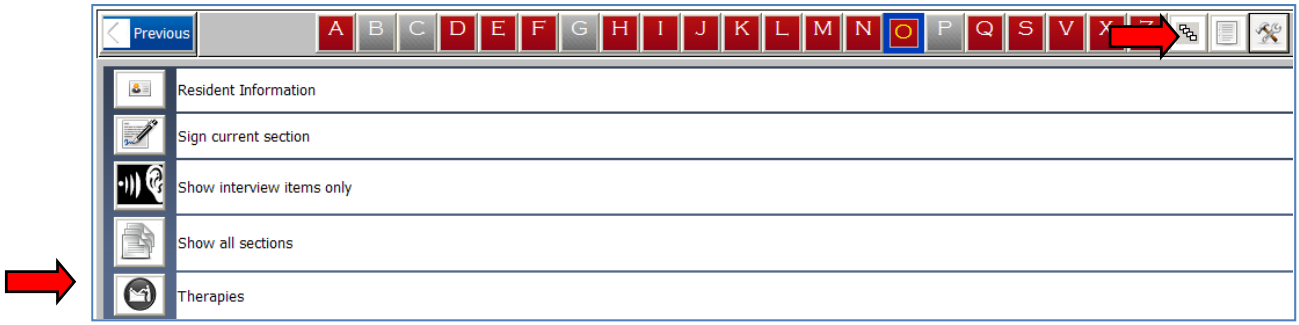
Click on the tool icon and then on the "MDS 3.0 Drug Class Index" icon. The following screen appears:



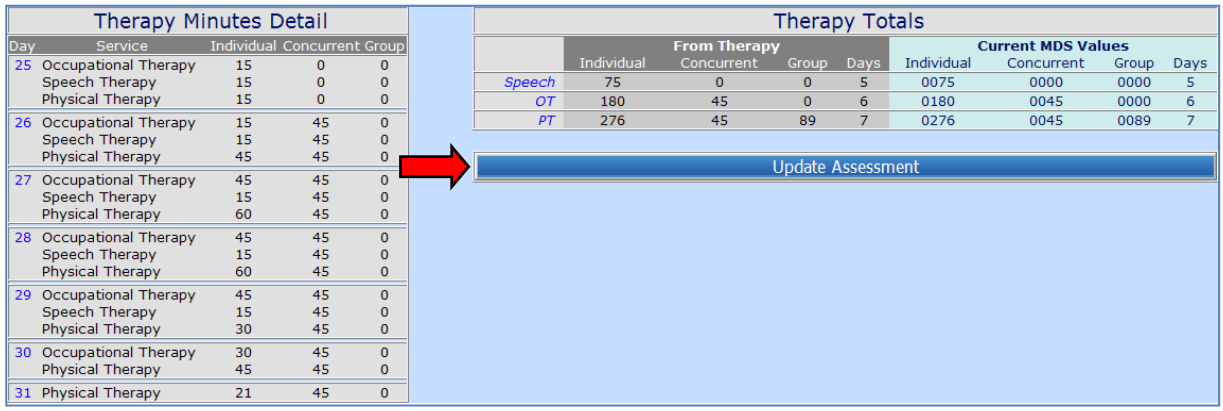
Note that the medications appear only if you are using the VISUAL Electronic Medical Records (EMR) modules.

Import Therapy Minutes for Section "O"

To import therapy minutes from the Therapy module into section "O" of the MDS click on the tool icon and then on the Therapy icon as shown below:

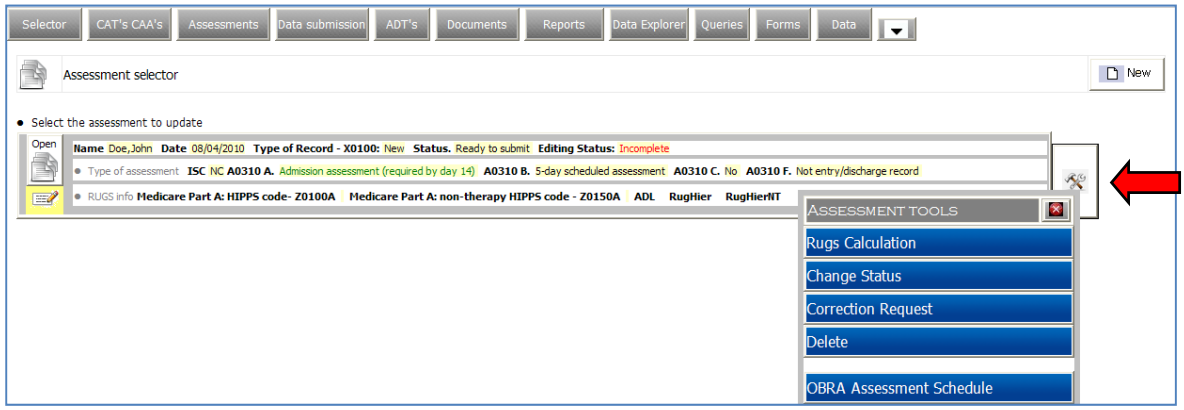

Previous
A B C D E F G H I J K L M N O P Q S V X Z
Resident Information
Sign current section
Show interview items only
Show all sections
Therapies

The following screen appears showing therapy services performed, and the current values in Section "O" of the MDS:


Therapy Minutes Detail
Day Service Individual Concurrent Group
25 Occupational Therapy 15 0 0
Speech Therapy 15 0 0
Physical Therapy 15 0 0
26 Occupational Therapy 15 45 0
Speech Therapy 15 45 0
Physical Therapy 45 45 0
27 Occupational Therapy 45 45 0
Speech Therapy 15 45 0
Physical Therapy 60 45 0
28 Occupational Therapy 45 45 0
Speech Therapy 15 45 0
Physical Therapy 60 45 0
29 Occupational Therapy 45 45 0
Speech Therapy 15 45 0
Physical Therapy 30 45 0
30 Occupational Therapy 30 45 0
Physical Therapy 45 45 0
31 Physical Therapy 21 45 0
Therapy Totals
From Therapy
Current MDS Values
Individual Concurrent Group Days Individual Concurrent Group Days
Speech 75 0 0 5 0075 0000 0000 5
OT 180 45 0 6 0180 0045 0000 6
PT 276 45 89 7 0276 0045 0089 7
Update Assessment

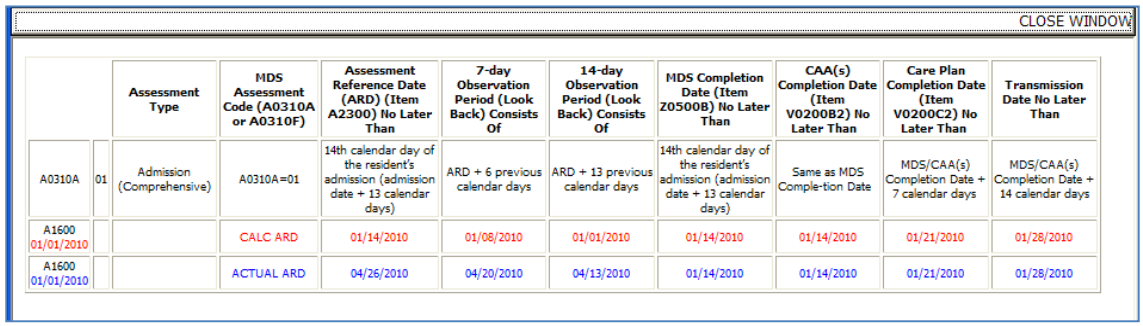
Click on "Update Assessment" as shown above to place the therapy values into Section "O" of the MDS. Click on Section "O" to go back to that section.

Assessment Tools


Selector
CAT's CAA's
Assessments
Data submission
ADT's
Documents
Reports
Data Explorer
Queries
Forms
Data
Assessment selector
New
Select the assessment to update
Open
Name Doe,John Date 08/04/2010 Type of Record - X0100: New Status. Ready to submit Editing Status: Incomplete
Type of assessment ISC NC A0310 A. Admission assessment (required by day 14) A0310 B. 5-day scheduled assessment A0310 C. No A0310 F. Not entry/discharge record
RUGS info Medicare Part A: HIPPS code- Z0100A Medicare Part A: non-therapy HIPPS code - Z0150A ADL RugHier RugHierNT
ASSESSMENT TOOLS
Rugs Calculation
Change Status
Correction Request
Delete
OBRA Assessment Schedule

When you click on the tool icon to the right of the assessment you obtain access to the following functionality:

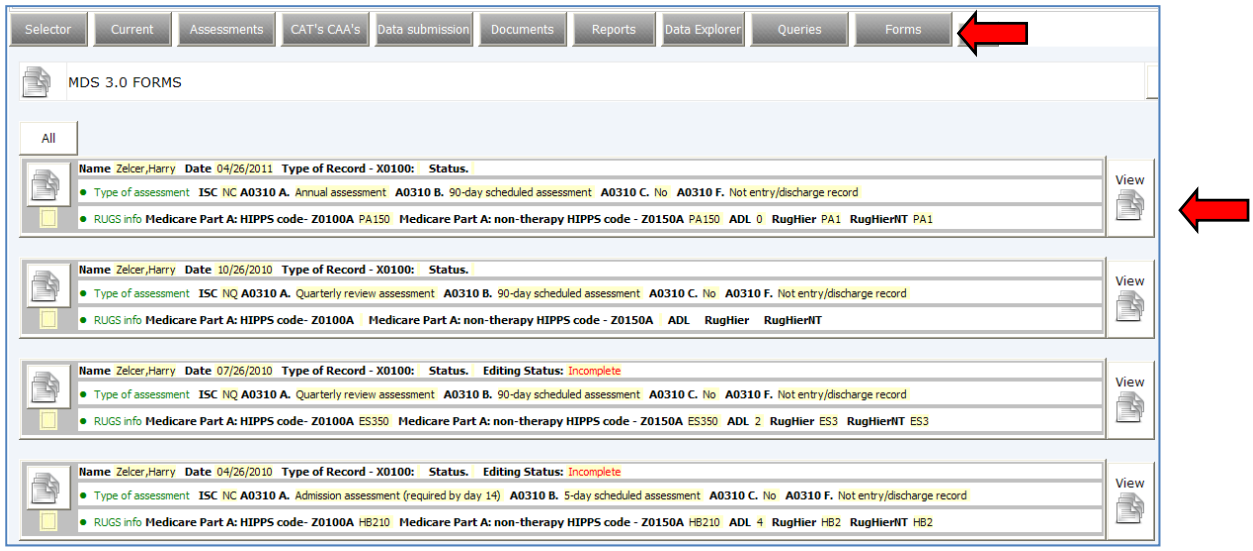
1. RUGs Calculation: To view a complete analysis of your RUGs score.
2. Change Status: The ability to change the submission status of the MDS record to "Ready to Submit", "Hold" and "Submitted".
3. Correction Request: Allows you to either modify the existing record or inactivate the existing record.
4. Delete: To delete the current record. This functionality is to allow you to delete your practice records. This functionality will be made more difficult after October 1st.
5. OBRA Assessment Schedule: A detailed listing of all the relevant dates that are calculated based on the Assessment Reference Date as follows:


CLOSE WINDOW

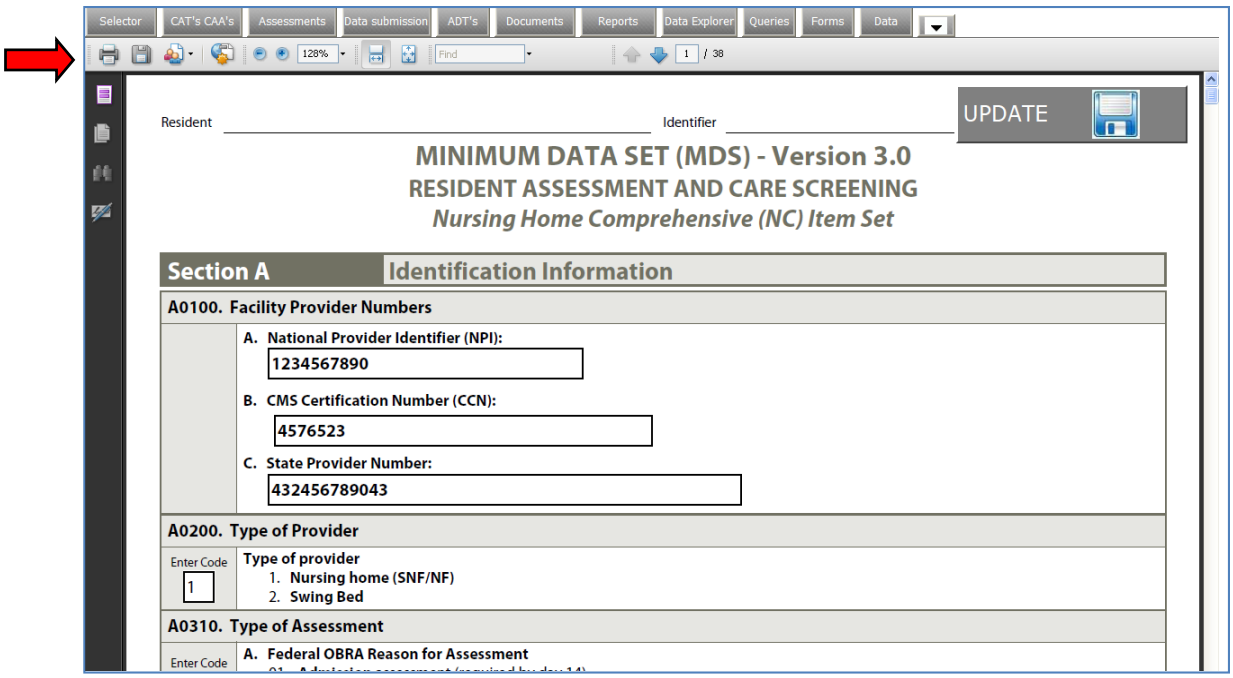
		Assessment Type	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than
A0310A	01	Admission (Comprehensive)	A0310A=01	14th calendar day of the resident's admission (admission date + 13 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day of the resident's admission (admission date + 13 calendar days)	Same as MDS Comple-tion Date	MDS/CAA(s) Completion Date + 7 calendar days	MDS/CAA(s) Completion Date + 14 calendar days
A1600 01/01/2010			CALC ARD	01/14/2010	01/08/2010	01/01/2010	01/14/2010	01/14/2010	01/21/2010	01/28/2010
A1600 01/01/2010			ACTUAL ARD	04/26/2010	04/20/2010	04/13/2010	01/14/2010	01/14/2010	01/21/2010	01/28/2010

Printing the MDS Record

To print an MDS do the following:



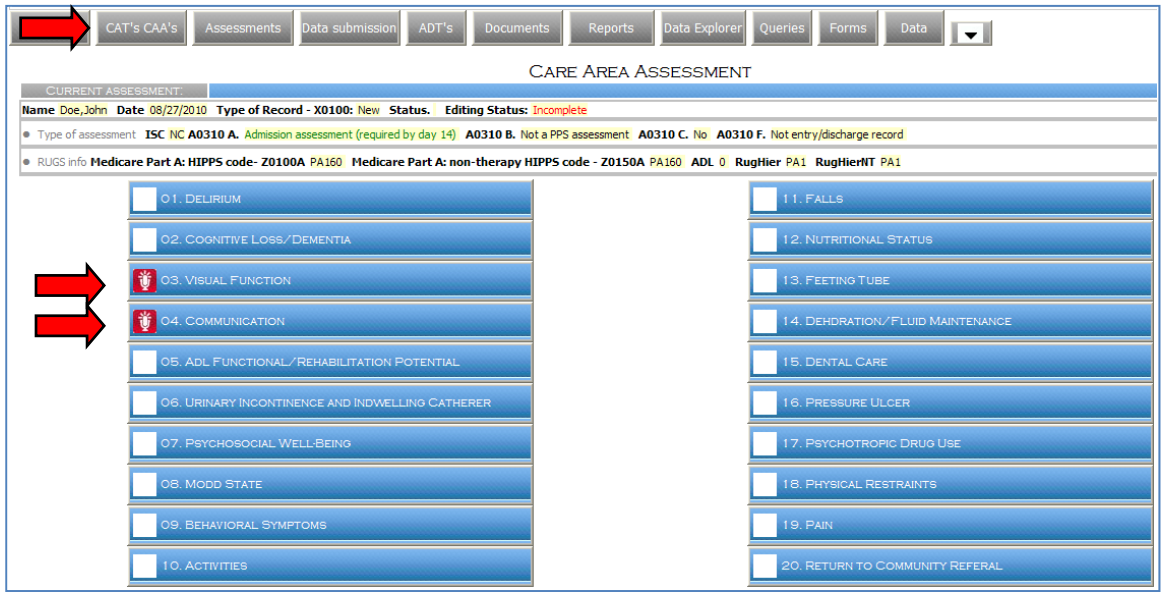
As shown above click on "Forms" and then click on the "View" icon alongside the MDS you wish to print. The form appears as shown below:



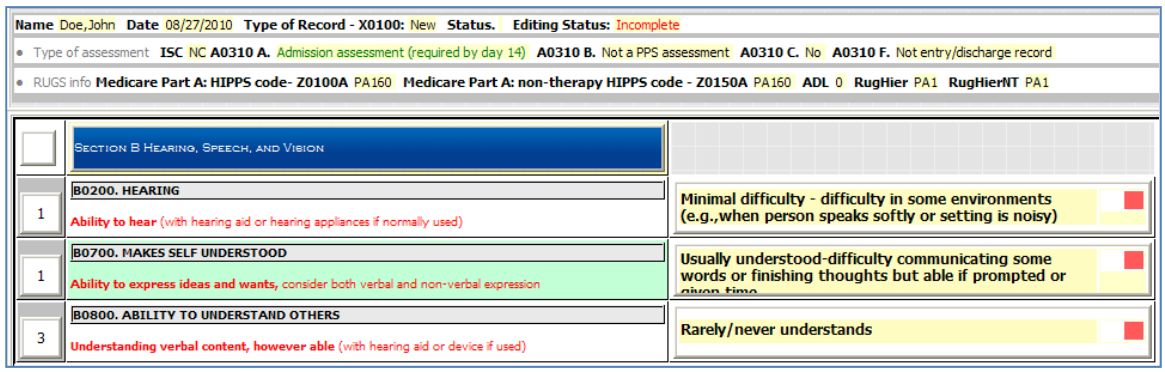
Click on the print icon as shown above to print the form.

Care Area Triggers (CATs)

Click on "CAT's CAA's" as shown below and the computer displays the CAT triggers:

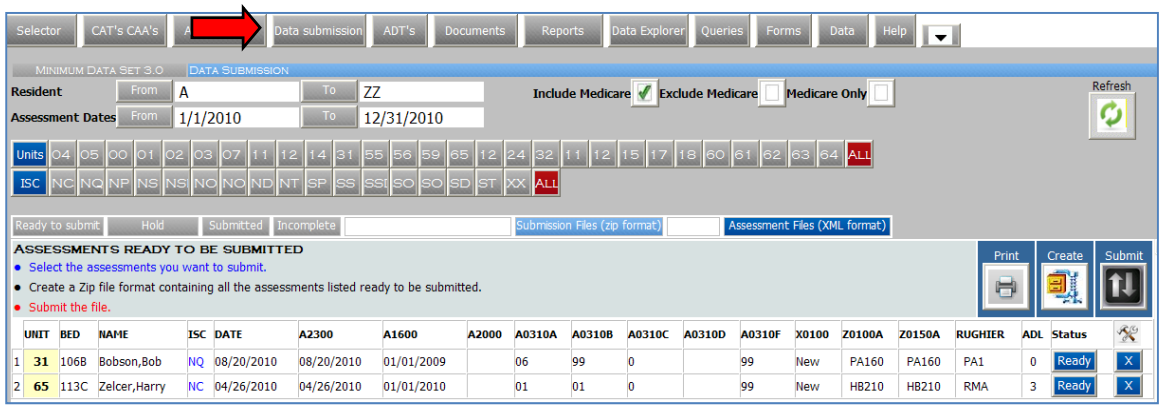

CAT's CAA's
Assessments
Data submission
ADT's
Documents
Reports
Data Explorer
Queries
Forms
Data
CARE AREA ASSESSMENT
CURRENT ASSESSMENT:
Name Doe,John Date 08/27/2010 Type of Record - X0100: New Status. Editing Status: Incomplete
Type of assessment ISC NC A0310 A. Admission assessment (required by day 14) A0310 B. Not a PPS assessment A0310 C. No A0310 F. Not entry/discharge record
RUGS info Medicare Part A: HIPPS code- Z0100A PA160 Medicare Part A: non-therapy HIPPS code - Z0150A PA160 ADL 0 RugHier PA1 RugHierNT PA1
01. DELIRIUM
02. COGNITIVE LOSS/DEMENTIA
03. VISUAL FUNCTION
04. COMMUNICATION
05. ADL FUNCTIONAL/REHABILITATION POTENTIAL
06. URINARY INCONTINENCE AND INDWELLING CATHERER
07. PSYCHOSOCIAL WELL-BEING
08. MODD STATE
09. BEHAVIORAL SYMPTOMS
10. ACTIVITIES
11. FALLS
12. NUTRITIONAL STATUS
13. FEETING TUBE
14. DEHDRATION/FLUID MAINTENANCE
15. DENTAL CARE
16. PRESSURE ULCER
17. PSYCHOTROPIC DRUG USE
18. PHYSICAL RESTRAINTS
19. PAIN
20. RETURN TO COMMUNITY REFERAL

Click on any triggered CAT as shown above (e.g., "Communication") and the computer displays the questions and answers that caused the triggers as shown below.


Name Doe,John Date 08/27/2010 Type of Record - X0100: New Status. Editing Status: Incomplete
Type of assessment ISC NC A0310 A. Admission assessment (required by day 14) A0310 B. Not a PPS assessment A0310 C. No A0310 F. Not entry/discharge record
RUGS info Medicare Part A: HIPPS code- Z0100A PA160 Medicare Part A: non-therapy HIPPS code - Z0150A PA160 ADL 0 RugHier PA1 RugHierNT PA1
SECTION B HEARING, SPEECH, AND VISION
B0200. HEARING
Ability to hear (with hearing aid or hearing appliances if normally used)
Minimal difficulty - difficulty in some environments (e.g.,when person speaks softly or setting is noisy)
B0700. MAKES SELF UNDERSTOOD
Ability to express ideas and wants, consider both verbal and non-verbal expression
Usually understood-difficulty communicating some words or finishing thoughts but able if prompted or
B0800. ABILITY TO UNDERSTAND OTHERS
Understanding verbal content, however able (with hearing aid or device if used)
Rarely/never understands

Submitting Your MDS Records

On the tool-bar click on "Data Submission" as shown below.



There are 4 steps to the submission process:

1. Specify the MDSs you wish to submit
2. Zip the selected MDSs and mark the records as "Submitted"
3. Copy the Zip file to your local drive
4. Log on to CMS and send the submission file

Step 1: Specify the MDSs you wish to submit:

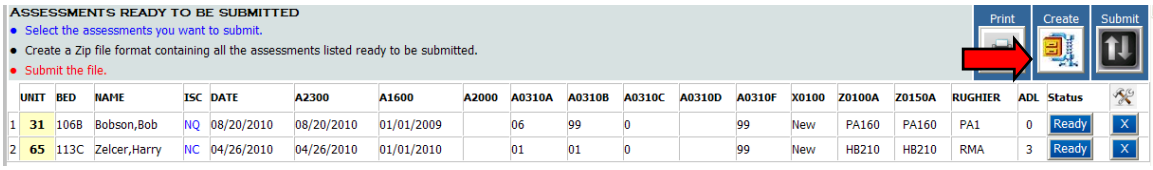
On the screen shown above specify which MDSs you wish to submit as follows:

1. Specify a resident alphabetical range.
2. Specify whether or not to include Medicare Assessments.
3. Specify the Assessment Reference Date Range.
4. Specify a single nursing unit or "all".
5. Specify a single Assessment Type or "all".

By clicking on any "Ready" button to the right of the MDS you can toggle the submission status of any MDS record between "Ready" and "Hold".

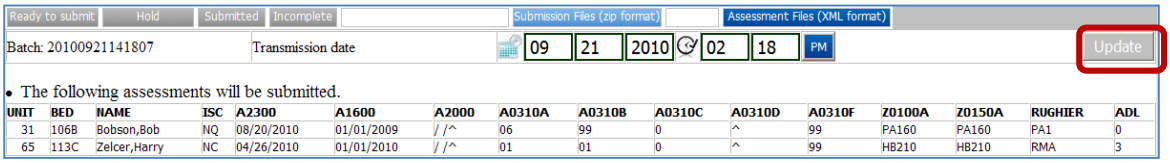
Step 2: ZIP the selected records and mark them as "Submitted":

Click the "Create" icon as shown below to ZIP (compress) the MDS records:


ASSESSMENTS READY TO BE SUBMITTED
Select the assessments you want to submit.
Create a Zip file format containing all the assessments listed ready to be submitted.
Submit the file.
Print
Create
Submit

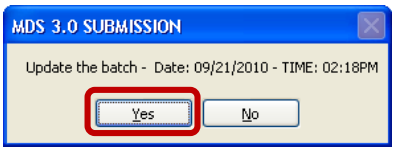
	UNIT	BED	NAME	ISC	DATE	A2300	A1600	A2000	A0310A	A0310B	A0310C	A0310D	A0310F	X0100	Z0100A	Z0150A	RUGHIER	ADL	Status	
1	31	106B	Bobson,Bob	NQ	08/20/2010	08/20/2010	01/01/2009		06	99	0		99	New	PA160	PA160	PA1	0	Ready	X
2	65	113C	Zelcer,Harry	NC	04/26/2010	04/26/2010	01/01/2010		01	01	0		99	New	HB210	HB210	RMA	3	Ready	X

The following screen appears showing the new ZIP file created:

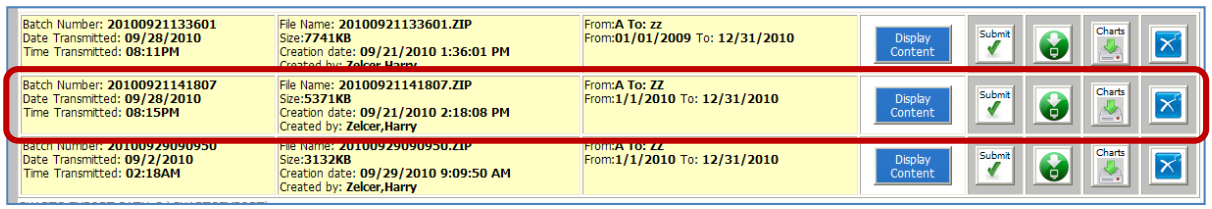


UNIT	BED	NAME	ISC	A2300	A1600	A2000	A0310A	A0310B	A0310C	A0310D	A0310F	Z0100A	Z0150A	RUGHIER	ADL
31	106B	Bobson,Bob	NQ	08/20/2010	01/01/2009	/ /^	06	99	0	^	99	PA160	PA160	PA1	0
65	113C	Zelcer,Harry	NC	04/26/2010	01/01/2010	/ /^	01	01	0	^	99	HB210	HB210	RMA	3

Notice above that the date and time are inserted. Click "Update" as shown above to mark these records as submitted and to create the file. You will be asked to confirm that you are marking the batch:



Click on "Yes" as shown above and your batch is created.



Notice above that the "File Name" and "Creation Date" both correspond to the submission date specified above.

To display the records in the batch click on "Display Content".

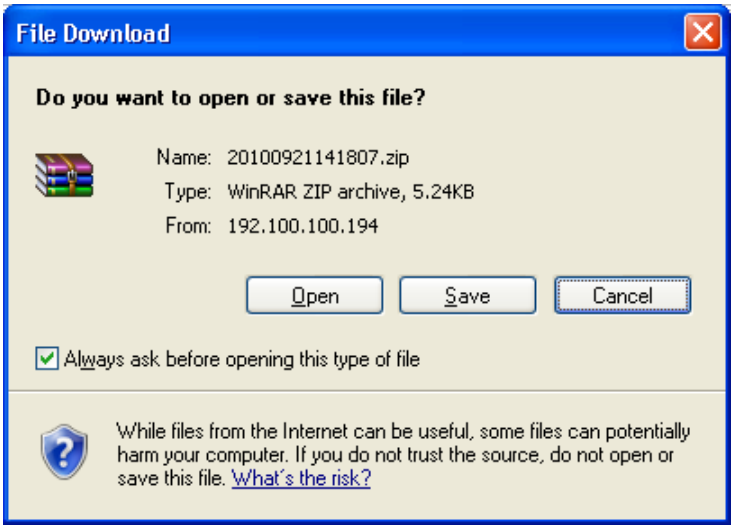
To export the records to CHARTS click on the "Charts" icon.

If you created a batch in error you can delete it by clicking on the white on blue "X". This deletes the batch but does not delete the MDS records.

Step 3. Copy the submission file to your local disk drive:

Copy the submission file to your local disk drive by clicking on

The following prompt appears:


File Download
Do you want to open or save this file?
Name: 20100921141807.zip
Type: WinRAR ZIP archive, 5.24KB
From: 192.100.100.194
Open
Save
Cancel
Always ask before opening this type of file
While files from the Internet can be useful, some files can potentially harm your computer. If you do not trust the source, do not open or save this file. What's the risk?

Notice that the file name is comprised of the date and time in "YYYYMMDDHHMMSS" format. Click on "Save" to save the file to a local disk Drive.

Step 4: Log on to CMS and transmit your file.

As per QIES Technical Support Office (www.qtso.com) "Transport Layer Security (TLS) 1.0 must be active in your web browser in order to access the QIES National Systems, including the new MDS 3.0 Submission System. Follow the steps below to activate TLS 1.0.

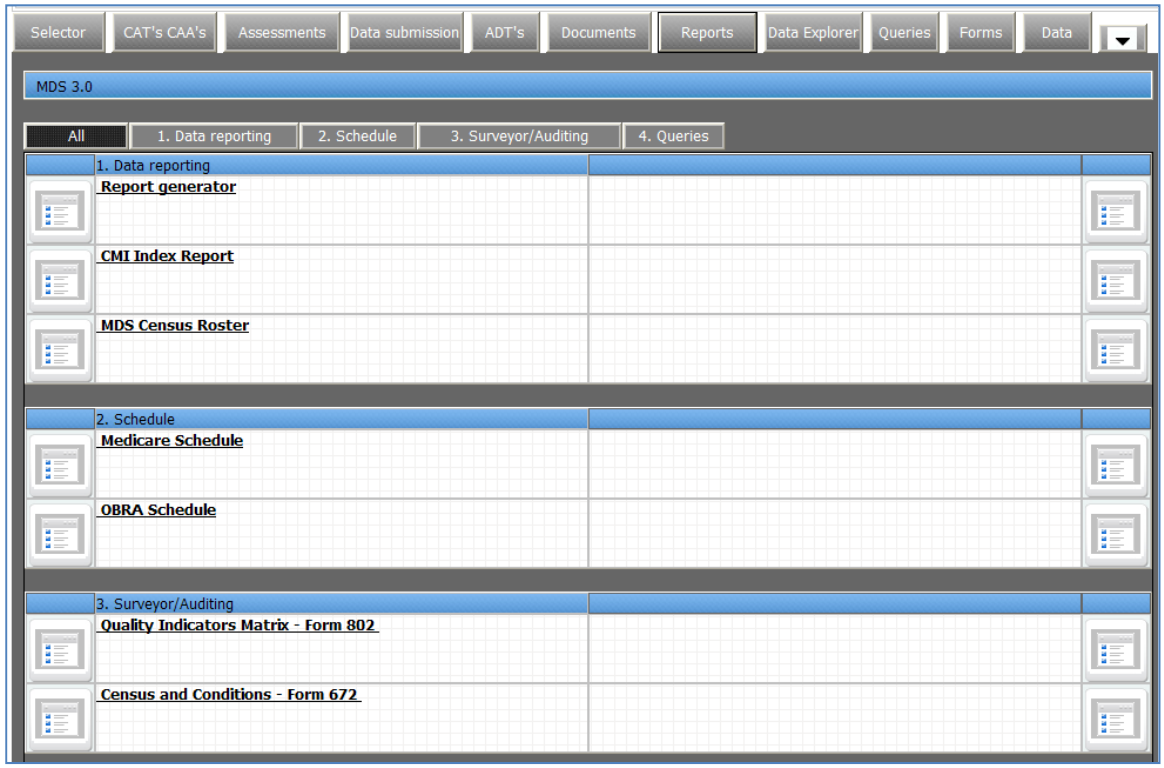
"**Note:** You must have administrative rights to your workstation in order to update this value. If you do not have administrative rights, contact your IT support.

1. Open the Internet Explorer browser.
2. Select "Tools" from the Menu bar.
3. Click on "Internet Options".
4. Select the "Advanced" tab.
5. Underneath "Security", ensure that the box next to "Use TLS 1.0" is checked (this should be located near the bottom of the list).
6. Click "Apply".
7. Click "Ok".

"If you have any questions concerning this information, please contact the QTSO Help Desk at help@qtso.com or 1 800-339-9313."

Reporting

Click on "Reports" to access the MDS 3.0 Report Generator and various other reports.

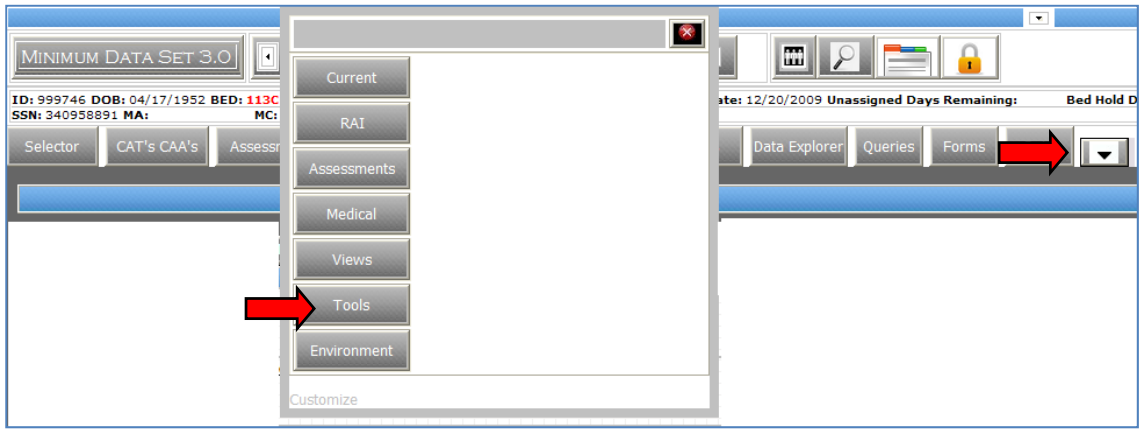


Click on the desired report and follow the instructions on the screen.

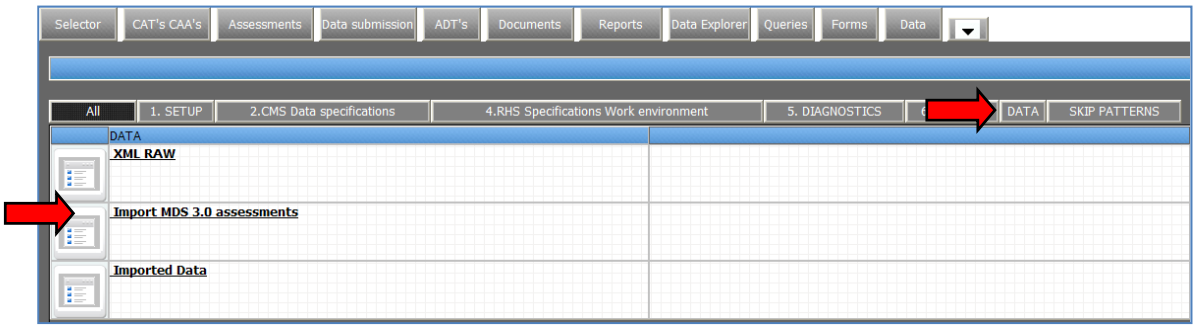
Importing MDS 3.0 Records

MDS records, either XML or flat, can be imported into VISUAL MDS 3.0 as follows:

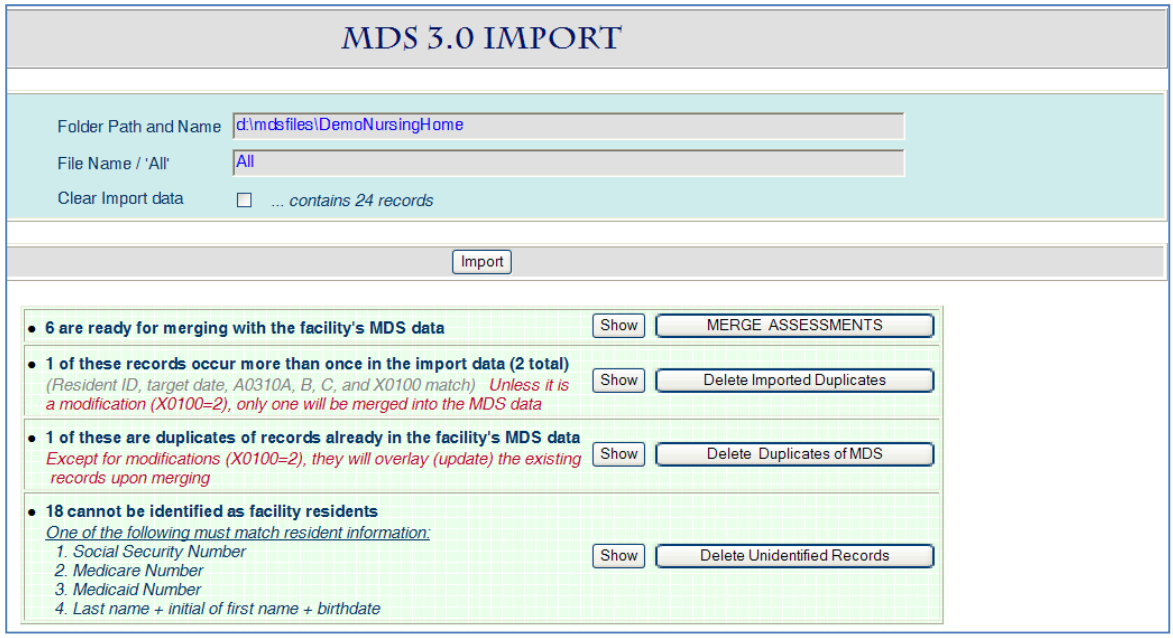
As shown below, click on the drop-down icon and select "Tools"



A shown below click on "Data" and then click on "Import MDS 3.0 Assessments".



The following screen appears:


MDS 3.0 IMPORT
Folder Path and Name
d:\mdsfiles\DemoNursingHome
File Name / 'All'
All
Clear Import data
... contains 24 records
Import
6 are ready for merging with the facility's MDS data
Show
MERGE ASSESSMENTS
1 of these records occur more than once in the import data (2 total)
(Resident ID, target date, A0310A, B, C, and X0100 match) Unless it is a modification (X0100=2), only one will be merged into the MDS data
Show
Delete Imported Duplicates
1 of these are duplicates of records already in the facility's MDS data
Except for modifications (X0100=2), they will overlay (update) the existing records upon merging
Show
Delete Duplicates of MDS
18 cannot be identified as facility residents
One of the following must match resident information:
1. Social Security Number
2. Medicare Number
3. Medicaid Number
4. Last name + initial of first name + birthdate
Show
Delete Unidentified Records

There are four logical steps to import MDS records:

1. Import the MDS records into a temporary work area.
2. Review the records to be imported and those that are duplicates.
3. Match manually (i.e., match the MDS to the proper resident) for those records that cannot be matched by the system.
4. Import the MDSs ("Merge Assessments".)

Step 1: Import the MDS records into a temporary work area

On the top part of the screen shown above type the following:

At "Folder Path and Name" type the complete path of the files to be imported.

At "File Name / 'All' " type the name of the file to be imported or "All" to import all files in the directory specified above.

At "Clear Import Data" place a check-mark to wipe out any records in the temporary work area (i.e., that are still there from your previous import). Notice that it shows how many MDS records are in the temporary work area.

Click on "Import".

Step 2: Review the records to be imported and those that are duplicate

For each of the following four types of records click on "Show" in the screen below to see a listing of the MDSs:

1. MDS Records in the import file that were successfully matched with residents in the VISUAL census data-base.
2. Duplicate MDSs in the import batch (i.e., the imported records contained 2 or more records for the same resident, MDS type and date.) *Unless it is a modification (X0100=2), only one will be merged into the MDS data.*
3. MDS records in the imported batch that have matching records in the VISUAL MDS data-base. *Except for modifications (X0100=2), they will overlay (update) the existing records upon merging.*
4. MDS records that could not be matched up with any resident in the VISUAL data-base. You will need to match these records manually.

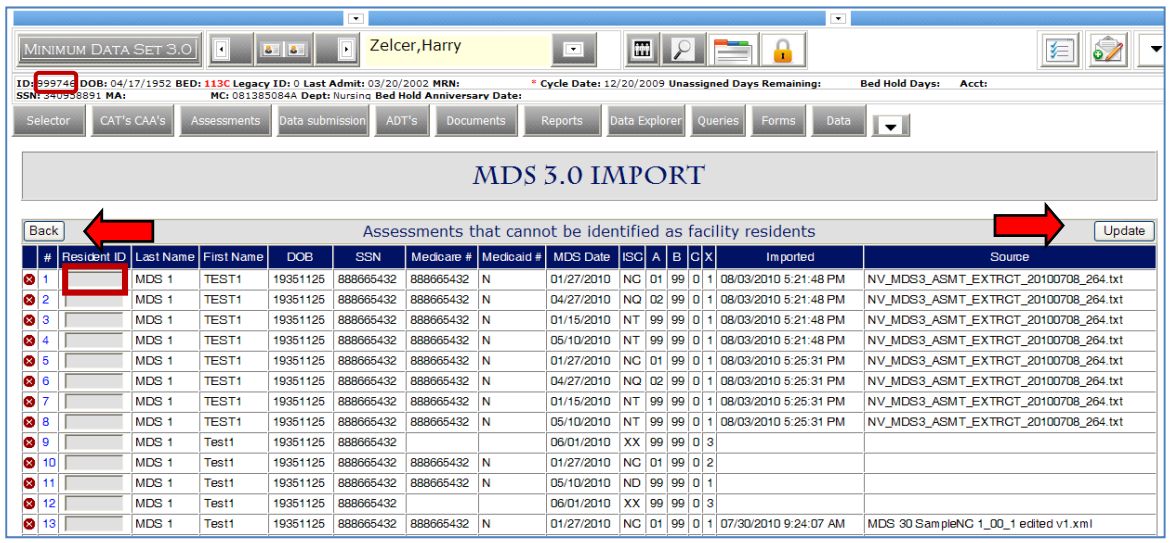
• 6 are ready for merging with the facility's MDS data
Show
MERGE ASSESSMENTS
• 1 of these records occur more than once in the import data (2 total)
(Resident ID, target date, A0310A, B, C, and X0100 match) Unless it is a modification (X0100=2), only one will be merged into the MDS data
Show
Delete Imported Duplicates
• 1 of these are duplicates of records already in the facility's MDS data
Except for modifications (X0100=2), they will overlay (update) the existing records upon merging
Show
Delete Duplicates of MDS
• 18 cannot be identified as facility residents
One of the following must match resident information:
1. Social Security Number
2. Medicare Number
3. Medicaid Number
4. Last name + initial of first name + birthdate
Show
Delete Unidentified Records

Step 3: Identify manually the records that cannot be identified by the program

You will need to manually match up any imported MDS Records that could not be matched by the system to a specific VISUAL resident. The match them do the following:

6 are ready for merging with the facility's MDS data
Show
MERGE ASSESSMENTS
1 of these records occur more than once in the import data (2 total)
(Resident ID, target date, A0310A, B, C, and X0100 match) Unless it is a modification (X0100=2), only one will be merged into the MDS data
Show
Delete Imported Duplicates
1 of these are duplicates of records already in the facility's MDS data
Except for modifications (X0100=2), they will overlay (update) the existing records upon merging
Show
Delete Duplicates of MDS
18 cannot be identified as facility residents
One of the following must match resident information:
1. Social Security Number
2. Medicare Number
3. Medicaid Number
4. Last name + initial of first name + birthdate
Show
Delete Unidentified Records

Click on "Show" as shown above and the following report appears:



#	Resident ID	Last Name	First Name	DOB	SSN	Medicare #	Medicaid #	MDS Date	ISC	A	B	C	X	Imported	Source
1		MDS 1	TEST1	19351125	888665432	888665432	N	01/27/2010	NC	01	99	0	1	08/03/2010 5:21:48 PM	NV_MDS3_ASMT_EXTRCT_20100708_264.txt
2		MDS 1	TEST1	19351125	888665432	888665432	N	04/27/2010	NQ	02	99	0	1	08/03/2010 5:21:48 PM	NV_MDS3_ASMT_EXTRCT_20100708_264.txt
3		MDS 1	TEST1	19351125	888665432	888665432	N	01/15/2010	NT	99	99	0	1	08/03/2010 5:21:48 PM	NV_MDS3_ASMT_EXTRCT_20100708_264.txt
4		MDS 1	TEST1	19351125	888665432	888665432	N	05/10/2010	NT	99	99	0	1	08/03/2010 5:21:48 PM	NV_MDS3_ASMT_EXTRCT_20100708_264.txt
5		MDS 1	TEST1	19351125	888665432	888665432	N	01/27/2010	NC	01	99	0	1	08/03/2010 5:25:31 PM	NV_MDS3_ASMT_EXTRCT_20100708_264.txt
6		MDS 1	TEST1	19351125	888665432	888665432	N	04/27/2010	NQ	02	99	0	1	08/03/2010 5:25:31 PM	NV_MDS3_ASMT_EXTRCT_20100708_264.txt
7		MDS 1	TEST1	19351125	888665432	888665432	N	01/15/2010	NT	99	99	0	1	08/03/2010 5:25:31 PM	NV_MDS3_ASMT_EXTRCT_20100708_264.txt
8		MDS 1	TEST1	19351125	888665432	888665432	N	05/10/2010	NT	99	99	0	1	08/03/2010 5:25:31 PM	NV_MDS3_ASMT_EXTRCT_20100708_264.txt
9		MDS 1	Test1	19351125	888665432			06/01/2010	XX	99	99	0	3		
10		MDS 1	Test1	19351125	888665432	888665432	N	01/27/2010	NC	01	99	0	2		
11		MDS 1	Test1	19351125	888665432	888665432	N	05/10/2010	ND	99	99	0	1		
12		MDS 1	Test1	19351125	888665432			06/01/2010	XX	99	99	0	3		
13		MDS 1	Test1	19351125	888665432	888665432	N	01/27/2010	NC	01	99	0	1	07/30/2010 9:24:07 AM	MDS 30 SampleNC 1_00_1 edited v1.xml

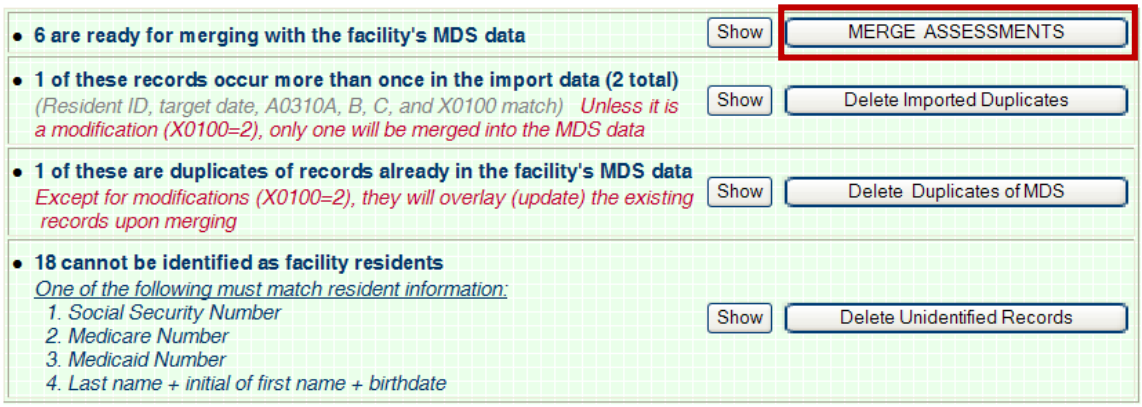
To match an MDS record to the appropriate resident, locate the appropriate resident (using for example the magnifying glass icon). Cut-and-paste the resident id alongside the appropriate MDS record as shown above.

Click on "Update". Repeat for each MDS record.

When you are done click on "Back". Continue with the instructions shown on the following page.

Step 4: Importing MDS Records

When you are done click on "Merge Assessments" as shown below.


6 are ready for merging with the facility's MDS data
Show
MERGE ASSESSMENTS
1 of these records occur more than once in the import data (2 total)
(Resident ID, target date, A0310A, B, C, and X0100 match) Unless it is a modification (X0100=2), only one will be merged into the MDS data
Show
Delete Imported Duplicates
1 of these are duplicates of records already in the facility's MDS data
Except for modifications (X0100=2), they will overlay (update) the existing records upon merging
Show
Delete Duplicates of MDS
18 cannot be identified as facility residents
One of the following must match resident information:
1. Social Security Number
2. Medicare Number
3. Medicaid Number
4. Last name + initial of first name + birthdate
Show
Delete Unidentified Records

The MDSs are now imported.

Visual Software

MDS 3.0 Report Generator

User Manual

PRELIMINARY

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Reliable Health Systems, LLC
2610 Nostrand Avenue
Brooklyn, NY 11210

www.ReliableHealth.com

Tel: 718-338-2400
Fax: 718-338-2741

VISUAL MDS 3.0 Report Generator
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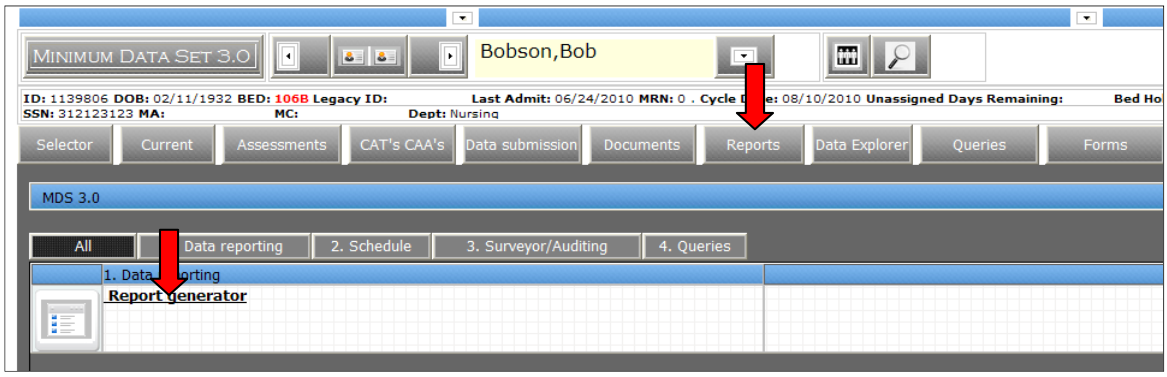
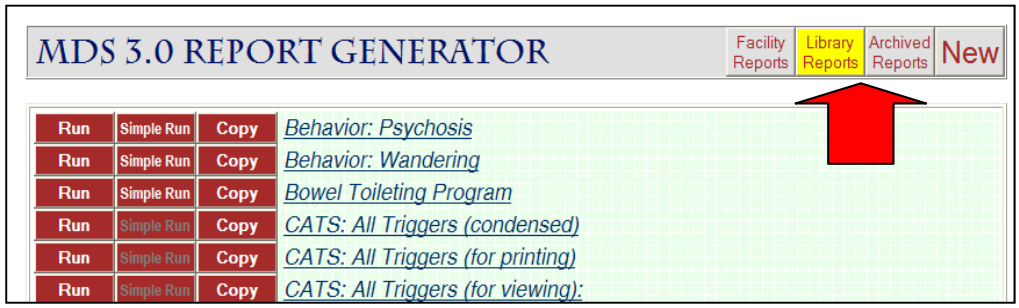
Selecting the MDS 3.0 Report Generator

On the vertical toolbar shown below click on "Reports" and then click on "Report Generator."



The following screen appears:



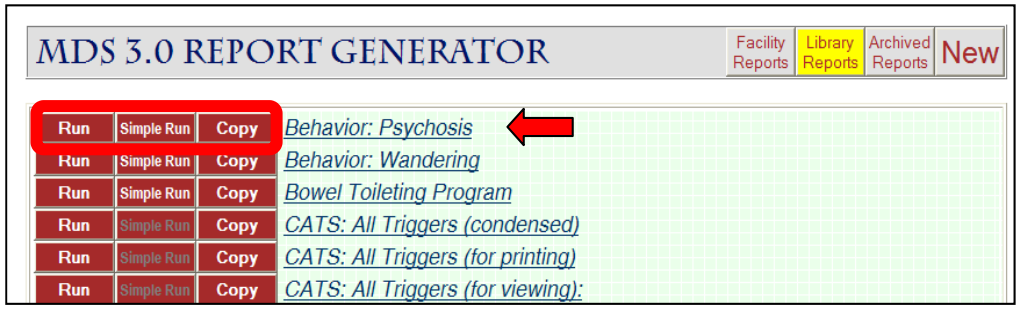
In the above screen notice the 4 choices:

Facility Reports:	These are reports that your facility creates.
Library Reports:	These are reports created by RHS.
Archived Reports:	Reports you deleted.
New:	Create a new report.

Of the above four choices notice that "Library Reports" is highlighted in yellow. Click on any of the buttons to change screens.

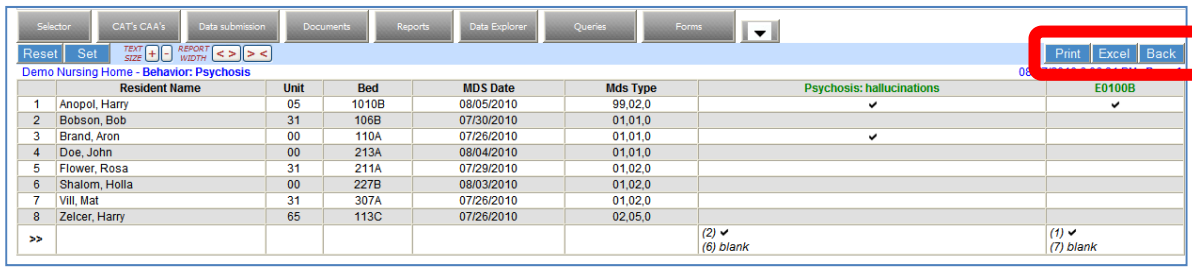
Running a "Library" Report created by RHS

On the screen below notice that alongside each report there are three functions from which to choose:



Run: Press "Run" alongside the name of the report you wish to run. For example, press "Run" alongside "Behavior: Psychosis". The report displays those residents on the MDS who were identified as having a Psychosis problem. It is set to look at the last complete assessment for each resident and only those residents that are active now. The conditions set for Psychosis is that either E0100A or E0100B has a checkmark.

Simple Run: Press "Simple Run" to run the report without setting any conditions. For example, press "Simple Run" alongside "Behavior: Psychosis". The report displays all residents and their responses for "psychosis behavior," regardless of whether or not the resident has a Psychosis problem. A sample report follows: (Note: When "Simple Run" is grayed-out, as shown above alongside the CAT reports it signifies that there are no conditions associated with the report.)



	Resident Name	Unit	Bed	MDS Date	Mds Type	Psychosis: hallucinations	E0100B
1	Anopol, Harry	05	1010B	08/05/2010	99,02,0	✔	✔
2	Bobson, Bob	31	106B	07/30/2010	01,01,0		
3	Brand, Aron	00	110A	07/26/2010	01,01,0	✔	
4	Doe, John	00	213A	08/04/2010	01,01,0		
5	Flower, Rosa	31	211A	07/29/2010	01,02,0		
6	Shalom, Holla	00	227B	08/03/2010	01,02,0		
7	Vill, Mat	31	307A	07/26/2010	01,02,0		
8	Zelcer, Harry	65	113C	07/26/2010	02,05,0		
>>						(2) ✔ (6) blank	(1) ✔ (7) blank

Click the "**Print**" button above right to print to whatever printer is attached to your workstation. Click "**Excel**" to copy the report to an Excel worksheet. Click "**Back**" to go to the previous screen. Use the following icons to increase or decrease text size and report width. Click "**Set**" to save the format or "**Reset**" to original.

Copy an RHS "Library" Report into your "Facility" Reports

Copy: Press **Copy** as shown on a screen above and a copy of the report will appear in your "Facility Reports." You can then modify this copy to suit the needs of your facility. Notice below that a copy of the report now appears in your "Facility Reports":

MDS 3.0 REPORT GENERATOR
Facility Reports
Library Reports
Archived Reports
New
Run Simple Run Copy Edit Archive Behavior: Psychosis
Run Simple Run Copy Edit Archive Behavior: Wandering
Run Simple Run Copy Edit Archive Bowel Toileting Program
Run Simple Run Copy Edit Archive CATs -- All Triggers: with Headings and Totals
Run Simple Run Copy Edit Archive CATs --Simple Chart
Run Simple Run Copy Edit Archive CATs: All Triggers (condensed)
Run Simple Run Copy Edit Archive CATs: All Triggers (for printing)
Run Simple Run Copy Edit Archive CATs: All Triggers (for viewing)
Run Simple Run Copy Edit Archive CATs: All Triggers: 1- 10

When reports are copied into your "Facility Reports" you have two new options:

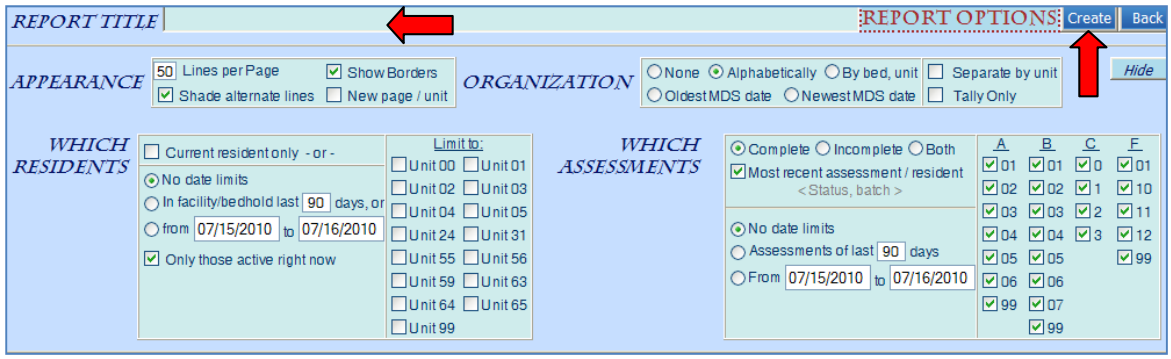
Edit: This allows you to make changes to the report including adding items, modifying or adding conditions and modifying formatting. The conditions of the report are what you set to see the specific results you are looking for. For example the conditions for the Facility report 'Behavior: Psychosis' is set to return those residents who have a checkmark in E0100A or E100B.

Archive: This allows you to delete the report.

Creating a New Report

As shown below click on "New" to create a new report.

The following screen appears:



At "Report Title" type the name of a report you would like to create. For example, to create a report that shows all residents with hearing aids type "Residents With Hearing Aids" and then click on "Create". The following screen appears:

In the above (and on the following) screen there are four sections:

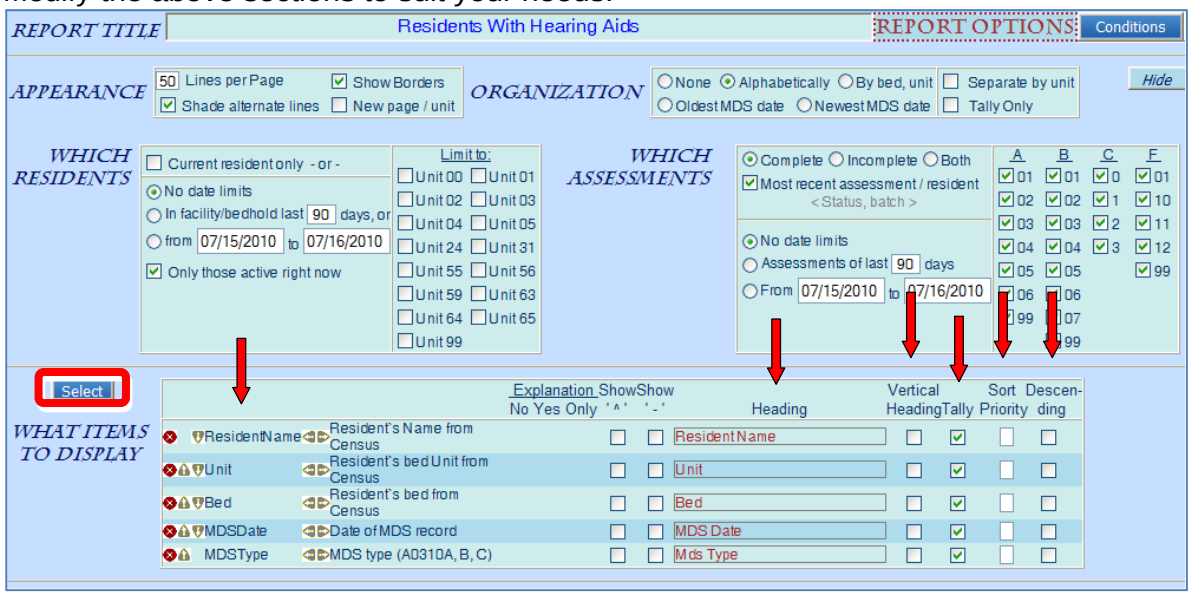
Appearance: Specify the appearance of the new report. Choose from several formatting options including New page /unit which will create a new page for each unit.

Organization: Specify one of five basic print orders and choose to separate results by unit or to quickly show just the number of records returned with Tally Only

Which Residents: Select which residents should appear. Choose the report to run just for the resident who is currently in the resident box **or** choose to show residents that qualify when using one of three date choices **or** only for active residents. Limit the report to those residents in a selected unit or units.

Which Assessments: Select which assessments should appear. Choose to show only complete assessments. Check 'Most recent assessment' **or** uncheck and choose from three date ranges to include all assessments within the range you set. Include only the Type of Assessments (A0310) under A0310.A, A0310.B, A0310.C, and A0310.F.

Modify the above sections to suit your needs.

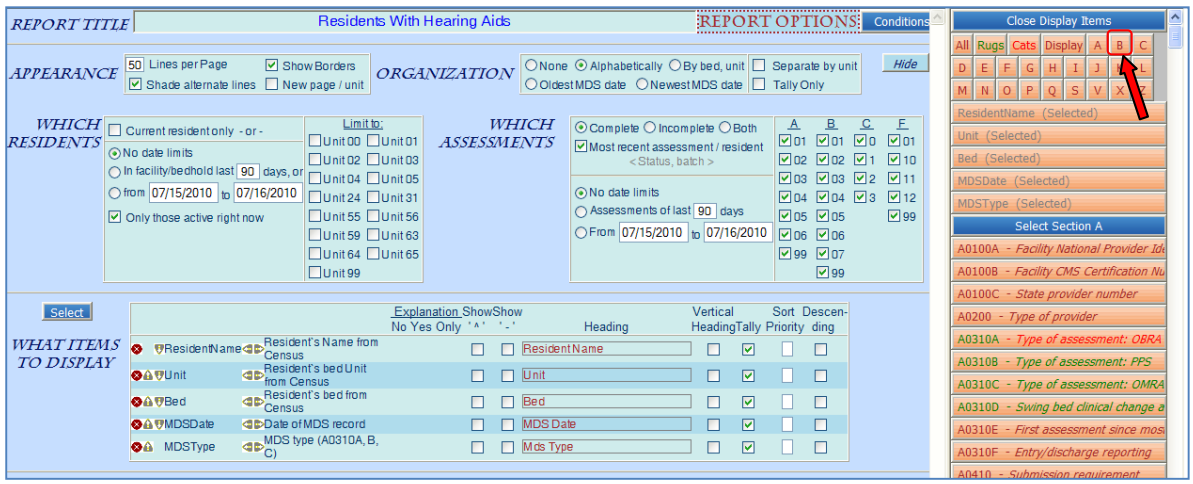


Notice the following:

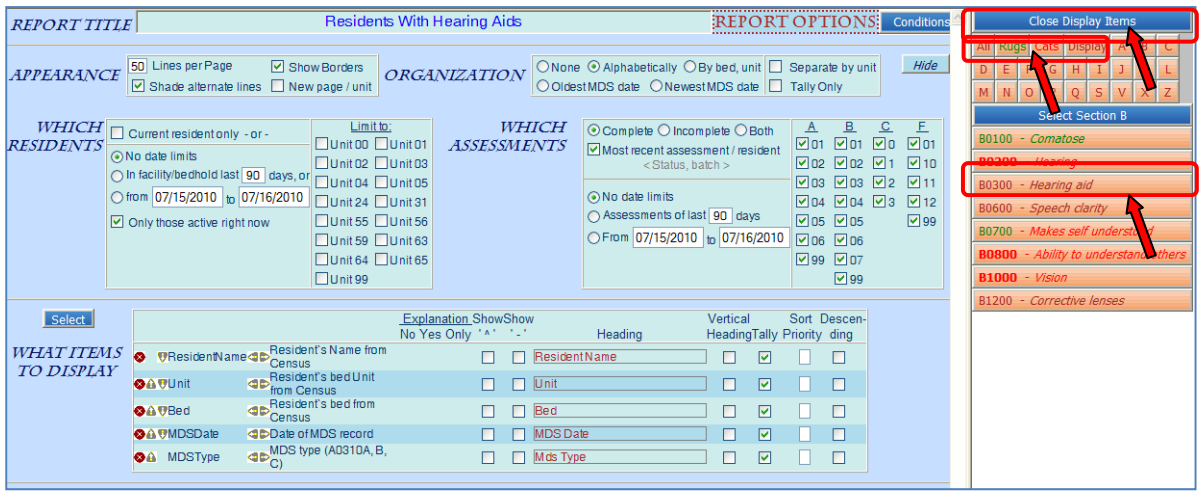
1. The report generator assumes that you want at least 5 fields on the report: the Resident's name, their unit and bed number, the date of the MDS, and the MDS type.
2. Each column heading is preset for you.
3. Print the header either horizontally (default) or vertically.
4. Tally the columns. Shows the totals for each response for that item
5. Put a check in Sort Priority to sort by that column. The default is by resident name.
6. Specify whether the column should be sorted ascending (default) or descending.

Choose 'Select' as shown circled above.

To add, for example, the "Hearing Aid" field, click on "Select" as circled above. The following screen appears:

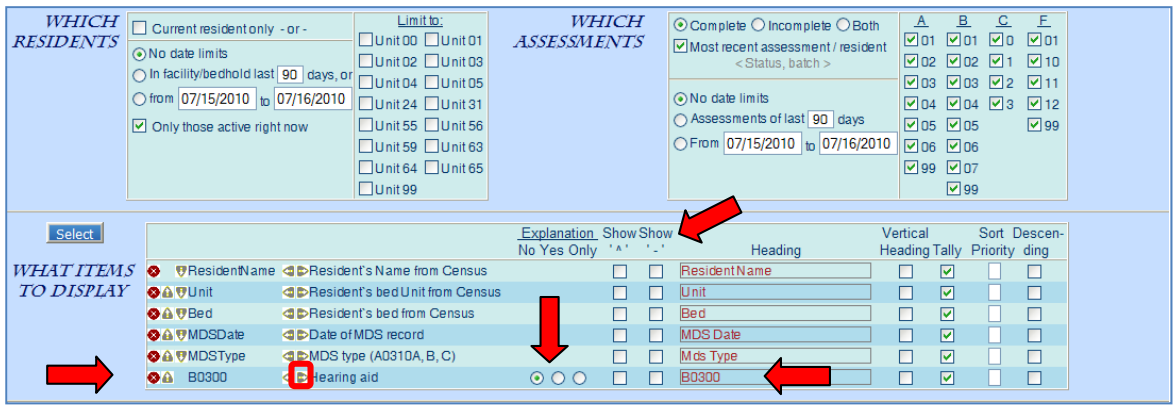


Since "Hearing Aid" is question "B0300" click on section "B" as shown above. The program now displays only the fields in Section B. (Note: As show below click **"All"** to show all available sections. Click **"RUGs"** or **"CATs"** to display all items that affect RUGs or CATs. Click **Close Display Items** to close.)



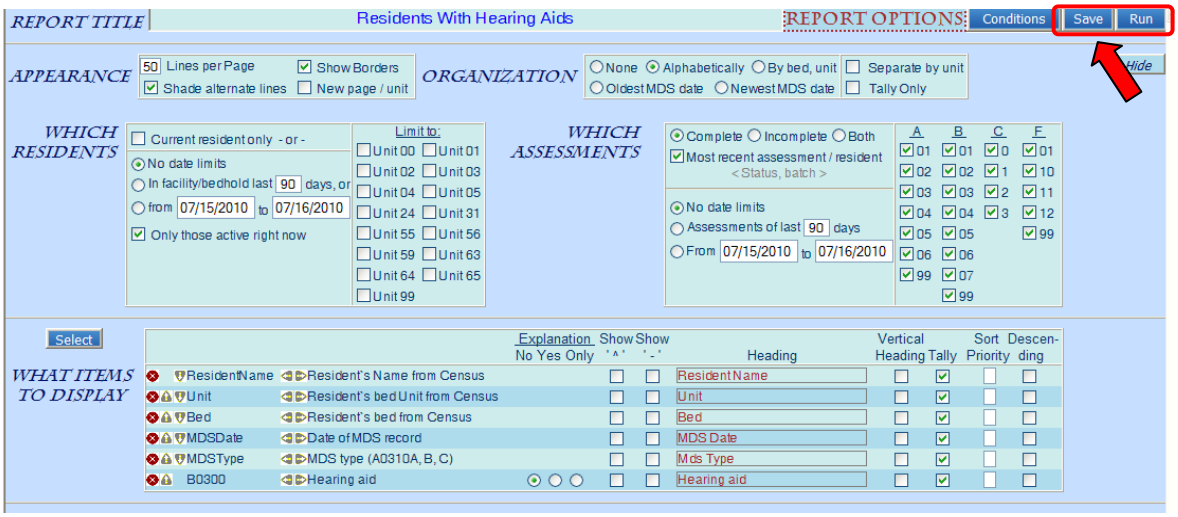
Click on "Hearing Aid" as shown above and then click on "Close Display Items".

As shown below "Hearing Aid" is now added to your report:



Notice in the above screen that the description of the column header was set to "B0300". To change it to "Hearing Aid" click on the icon circled above that points to the description "Hearing Aid". In the Explanation column you can format the content of the field using "No, Yes, or Only." (E.g., If B0200 was a column in the report you could show just the number '*3*' if "**No"** is selected; '*3=Highly impaired-absence of useful hearing*' if "**Yes"** is selected; or '*Highly impaired-absence of useful hearing*' if "**Only"** is selected.

In the two **Show** columns you can put a check in the '^ ' checkbox to show the '^ ' if section is answered 'Blank (skip pattern)'. Check the '-' checkbox to show the '-' for those items answered 'Not Assessed/no information' rather than a blank for that record in the report. A '^ ' or '-' is a considered a blank when totaled.



With the desired fields and column headers now in place click on **Run** as shown above. Clicking "RUN" runs the report and also saves your changes.
The following report is produced:

Reset | Set | Print | Excel | Back

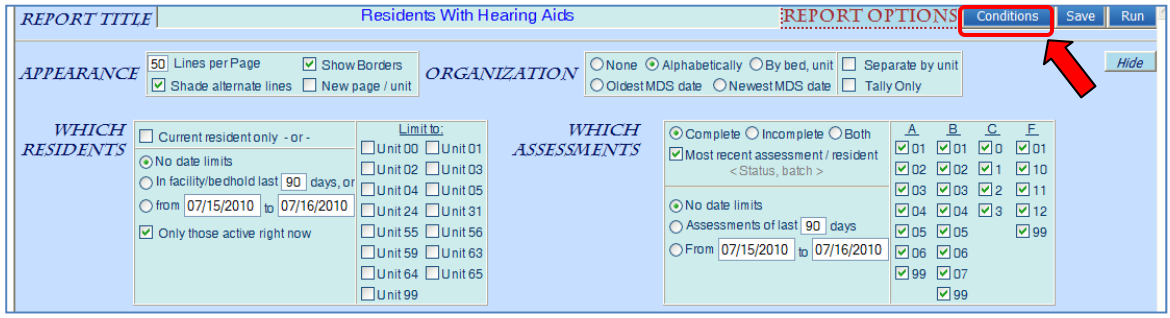
Demo Nursing Home - **Residents With Hearing Aids** 07/16/2010 3:45:16 PM Page 1

	Resident Name	Unit	Bed	MDS Date	Mds Type	Hearing aid
1	Bahmanesh, Sogol	00	237A	02/11/2010	06,99,0	
2	Baldi, Franki	63	100A	02/11/2010	06,99,0	
3	Berenstein, Jean	00	112B	02/11/2010	06,99,0	
4	Bobson, Bob	31	106B	02/01/2010	01,99,0	1
5	BumBaum, Valiza	00	240B	02/11/2010	06,99,0	
6	Dower, Jane	00	241C	02/11/2010	06,99,0	
7	Labrochette, Jean	00	236A	02/11/2010	06,99,0	
>>	*7 residents*	*7 listed* *3 distinct* *0 blank*	*7 listed* *7 distinct* *0 blank*	*2 distinct*	*2 distinct*	*(1) 1* *(1) listed* *(6) blank*

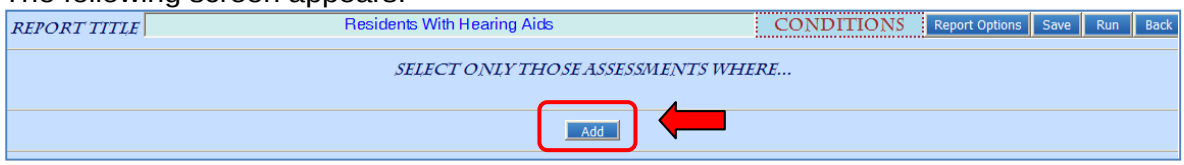
The report above shows how each resident was scored for "Hearing Aid".

Adding Conditions to Your Report

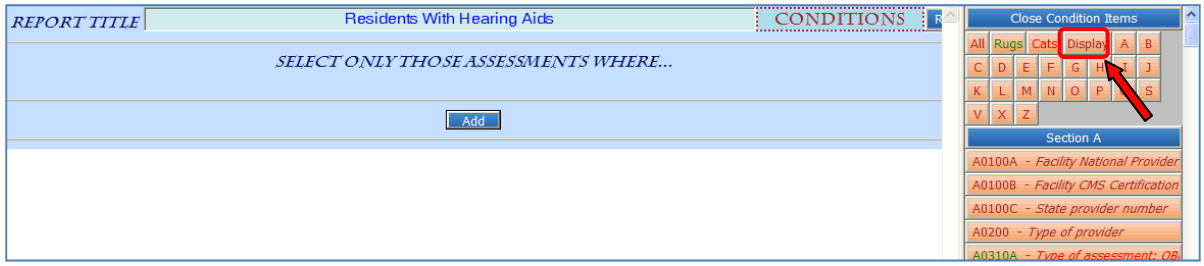
If you want to add a condition so that the report shows ***only*** those residents who have a hearing aid click on "Conditions" as shown below.



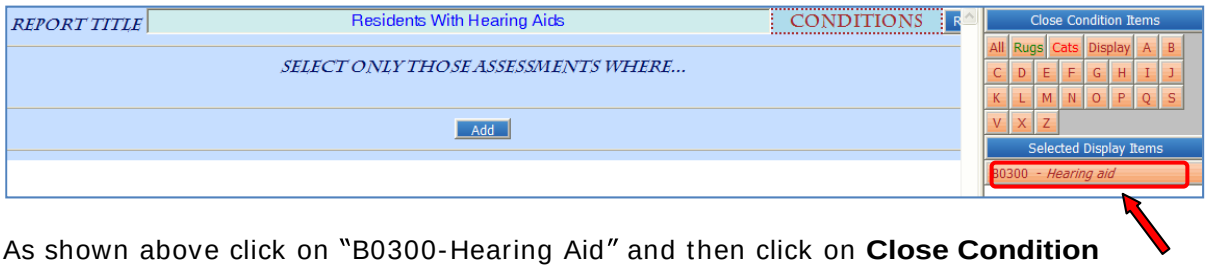
The following screen appears:



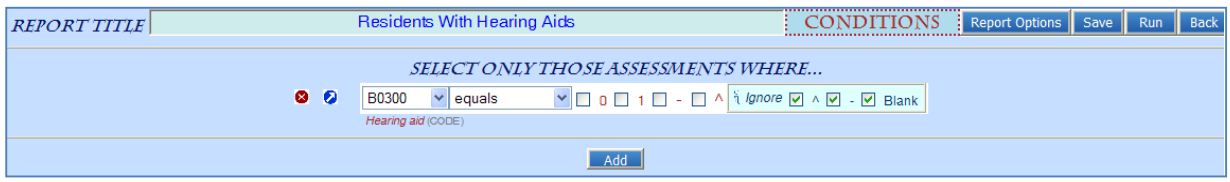
Click on **Add** as shown above. The following screen appears showing the available sections and items that can be added to the report:


REPORT TITLE
Residents With Hearing Aids
CONDITIONS
SELECT ONLY THOSE ASSESSMENTS WHERE...
Add
Close Condition Items
All Rugs Cats Display A B
C D E F G H I J
K L M N O P Q S
V X Z
Section A
A0100A - Facility National Provider
A0100B - Facility CMS Certification
A0100C - State provider number
A0200 - Type of provider
A0310A - Type of assessment: OB

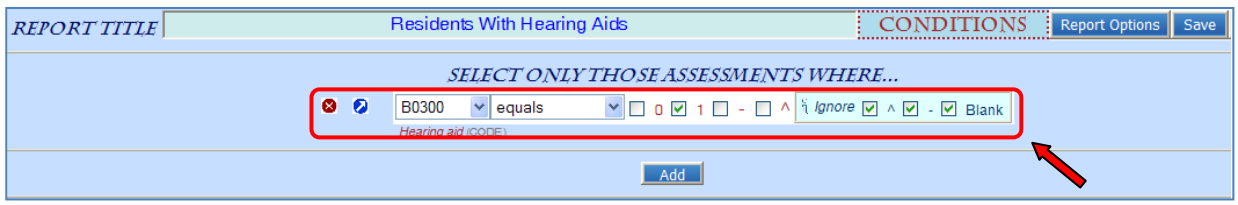
Click **Display** to show your previously selected fields.


REPORT TITLE
Residents With Hearing Aids
CONDITIONS
SELECT ONLY THOSE ASSESSMENTS WHERE...
Add
Close Condition Items
All Rugs Cats Display A B
C D E F G H I J
K L M N O P Q S
V X Z
Selected Display Items
B0300 - Hearing aid

As shown above click on "B0300-Hearing Aid" and then click on **Close Condition Items**. The condition field in now added as shown below. You can add any item to your report in the same way. Just find the section then item you want to add.



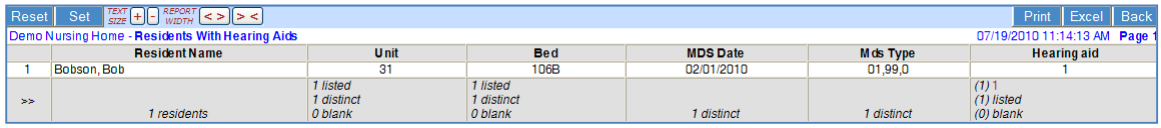
As shown below the little red 'x' deletes the condition. The little arrow to the right inserts a new condition above this one in the report. Next choose the the available options for setting the conditions for the item. Here the option for B0300 is either 'equals' or 'does not equals'. Click in front of the "1" to specify that only those residents with a hearing aid will appear on the report. Different items will have different options. Next you might ignore a caret or a dash (the default) because you want only to see those residents where B0300=1. Set the conditions of the item so that the report returns the records you're interested in seeing.



From the follwing menu options

click **Report Options** to return to the edit screen, **Save** to save your settings, **Run** to run the report or **Back** to return to the previous screen. When you click **Run** the report is

shown below. In this case only one resident satisfied the conditions of the report that you created.


Reset | Set | TEXT SIZE + - | REPORT WIDTH < > > < | Print | Excel | Back

Demo Nursing Home - **Residents With Hearing Aids** 07/19/2010 11:14:13 AM **Page 1**

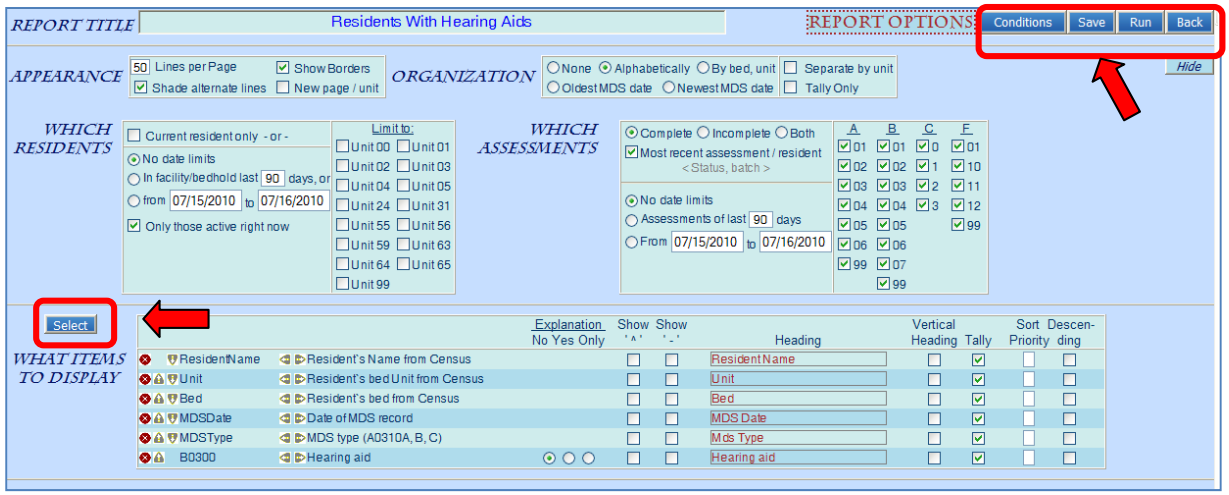
	Resident Name	Unit	Bed	MDS Date	Mds Type	Hearing aid
1	Bobson, Bob	31	106B	02/01/2010	01,99,0	1
>>	*1 residents*	*1 listed* *1 distinct* *0 blank*	*1 listed* *1 distinct* *0 blank*	*1 distinct*	*1 distinct*	*(1) 1* *(1) listed* *(0) blank*

Modifying a Previously Created Report

To modify a previously created report locate the report and click on **Edit** alongside the report as shown below.

Run Simple Run Copy Edit Archive Pressure Ulcers: Worsening Since Prior Assessment
Run Simple Run Copy Edit Archive Pressure Ulcers: Worsening Since Prior Assessment
Run Simple Run Copy Edit Archive Report
Run Simple Run Copy Edit Archive Residents With Hearing Aids
Run Simple Run Copy Edit Archive Restorative Nursing Program: Technique
Run Simple Run Copy Edit Archive Restorative Nursing Program: Train & Skill Practic

The following screen appears: You can edit the existing report or "Copy" the report, change the name and use this report as a base for a new report. You can then add new fields to the report or modify the existing fields. Click **Save** to save your new report.



There are six functions buttons on the screen to help you accomplish the following tasks:

Select: To add additional fields to the report.

Conditions: To add conditions to your report.

Save: To save your changes.

Run: To run your report. (Clicking "Run" also saves your changes.)

Back: Takes you back to your list of reports.

Color Coding for CATs (red) and RUGs (green)

Color coding is used throughout the MDS 3.0 VISUAL Report Generator to signify fields that affect CATs and RUGs as follows:

CAT fields are always coded red.

RUG fields are always coded green

When a field affects both CATs and RUGs both red and green are used. These colors appear when you select a field and also in the report columns.